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An Alternative Intervention for Bulimia

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Abstract

People with bulimia present with a variety of abnormal beliefs, attitudes, and behaviours. With few exceptions, studies to date have focused exclusively on the specific psychopathology of bulimia.

This controlled study of a brief group intervention did not directly address these behaviours. Based on a functional model of bulimia, the intervention aimed at expanding the subjects' repertoire of coping behaviours, and by cognitive restructuring, increase self-esteem and sense of wellbeing.

Twenty-four females (mean age = 31.97 years) who fulfilled the DSM-III criteria for bulimia, were recruited by newspaper advertisement. Subjects were matched into groups of three on the basis of their score on a measure of bulimia (Bulit: Smith & Thelen, 1984) and randomly allocated to one of two intervention groups or a waiting-list control. Each intervention consisted of seven two-hour sessions at weekly intervals and an optional one-hour individual session. The group interventions differed in that mental imagery tasks were included for one group. All subjects completed the intervention.

Intervention groups showed significant improvement on measures of bulimia, depression, anxiety, wellbeing and self-esteem, three weeks after intervention with further improvement at 3-month and 3-year follow-up. The waiting-list control group showed significant improvement in depression and wellbeing. By 3-month follow-up, 10 subjects (62.5%) no longer scored in the bulimic range on the Bulit. At 3-year follow-up, only 4 subjects (25%) scored in the bulimic range. Of 8 subjects who reported regular self-induced vomiting at pre-intervention, 6 (75%) were abstinent at 3-month follow-up and remained so at 3-year follow-up. The remaining 2 subjects reported a 75% reduction in their vomiting frequency. Outcome was not significantly correlated with age, subtype of bulimia, initial levels of anxiety, depression or self-esteem. While the duration of bulimic behaviours did not significantly correlate with outcome, the subjects' perceived duration of the eating disorder did show a significant correlation with outcome at post-intervention and 3-month follow-up.

Severity of bulimia was significantly different between the intervention groups at post-intervention and 3-month follow-up, but not at 3-year follow-up. Post-hoc comparison of these groups revealed a significant difference only in the perceived duration of the eating disorder.

The result of this study suggests that bulimic behaviours can be modified by an intervention which aims to expand the repertoire of coping and social skills rather than focusing on decreasing bulimic behaviours and cognitions.

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Last but not least many thanks to those who had enough trust to take part in the programme.

Dedication

This thesis is dedicated to my mother, Lily.

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Introduction

Since its inclusion into The Diagnostic and Statistical Manual of Mental Disorders (DSM-III, 1980)[1], the eating disorder bulimia has attracted increasing attention. It is well established that in Western societies women in general, and young women in particular, are often dissatisfied with their weight and shape (e.g., Chiodo & Latimer, 1985, Cash & Brown, 1987; Whitehouse, Freeman, & Annandale, 1986). Many diet or exercise in order to modify these, while others use more extreme methods, such as self-induced vomiting, diuretics, laxatives and starvation regimes. In bulimia these behaviours are accompanied by episodes of bingeing, self-depreciating thoughts and fear of fatness.

Treatments for the disorder have been numerous and varied. However, in spite of the growing body of research, relatively little is known about the etiology of this condition (Connors & Johnson, 1987). From simple behavioural (e.g., Rosen & Leitenberg, 1982,1985; Giles, Young, & Young, 1985), cognitive (Fairburn, 1981; Beck, 1976), and psychodynamic models (Bruch, 1973, 1978; Crisp, 1967, 1978; Connors & Johnson, 1987; Wilson, 1988), increasingly complex models have evolved (see Appendix A, page 70).

For example, Andersen (1987) provides a model incorporating behavioural, cognitive-behavioural, psychodynamic and pharmacological treatment procedures. It is now recognised that bulimia is a multi-dimensional problem, and issues such as why 90% of reported cases involve females, why the apparent prevalence of the disorder has been increasing over the last decade and occurs only in western cultures, and why some women appear more at risk than others, have attracted theorising by those from political (e.g., White & Boskind-White, 1983), feminist (e.g., Boskind-Lodahl, 1976; Chernin, 1983; Orbach, 1978; 1986), and family dynamic

[1]Refer to Appendix A, page 68 for definition, DSM-III criteria, and models of bulimia.

perspectives (e.g., Russell, Szmukler, Dare & Eisler, 1987; Strober, & Humphrey, 1987). An apparent link between bulimia, depression and anxiety (e.g., Johnson & Larson, 1982; Johnson-Sabine, Wood, & Wakeling, 1984; Fairburn, Cooper, Kirk, & O'Connor, 1985) has attracted the interest of those seeking to find a pharmaceutical cure (e.g., Jones & Gold, 1986; Sabine, Yonace, Farrington, Barrat, & Wakeling, 1983).

Although all the models offer more or less credible explanations of how the disorder self-perpetuates, particularly the cognitive-behavioural models, few have thrown much light on how individuals enter the binge-purge cycle which characterises bulimia. Perhaps because of this, most treatments to date have concentrated on breaking this cycle rather than examining any predisposing factors which may be causing or aggravating the disorder (e.g., Rosen & Leitenberg, 1982; 1985; Laessle, Zoettl, & Pirke, 1987). Typically, this involves focusing on specific bingeing and purging behaviours and attempting to modify these. Consequently success of treatments to date has been measured in terms of the frequency of the relatively easily quantifiable vomiting behaviour and the less quantifiable bingeing behaviour. Bingeing is a subjective term, which, for a person suffering from bulimia, may at times describe episodes as diverse as from eating one quarter of an apple to eating 20,000 calories. Few studies have attempted to define bingeing specifically. One exception is Wolchick, Weiss and Katzman (1986), who specified a binge as a discrete episode containing at least 1,200 calories. Other studies (e.g., Garner, 1986a; Hart & Ollendick, 1985) have left it to subjects to decide what constitutes a binge. However, not only is the amount of food, caloric content or type of food in a binge relevant but also the discrete time period such a binge involves. Hence, reducing the number of binges from three to one per day may not in itself necessarily constitute an improvement in the severity of bulimia. The one remaining binge may be longer, more calories may be ingested and/or the cognitions accompanying the binge may be more psychologically devastating to the individual than those he/she was suffering before. Thus, measuring success of an intervention in terms of reduced frequency of bingeing and purging behaviours may be misleading in that a severe problem may still exist in spite of this reduction. A further complication arising from the subjectivity of the term bingeing, is that a subject's concept of what constitutes a binge may change during treatment. Therefore, not only does bingeing differ from one person to another, it may also differ for an individual from one time to another, depending on his/her subjective feelings of fullness and/or accompanying cognitions.

In the attempt to normalise the behaviour of those suffering from this disorder, a number of underlying assumptions need to be examined. Although most theorists readily agree that vomiting behaviour, in the absence of illness or the ingestion of

noxious substances, is not normal, and therefore not desirable, bingeing behaviours are not so clear cut. It is usually considered normal in our society to occasionally eat considerably more than we need for energy sources, for example, Christmas, parties, funerals and so on, but bingeing is thought to be undesirable. At what point does overeating constitute a binge? What other factors are involved?

At this point, it might be appropriate to examine the criteria deemed necessary for the diagnosis of bulimia (DSM-III, 1980; DSM-III-R, 1987; refer to Appendix A, page 68). Although a person might overeat, this in itself is not sufficient for classification as bulimia, in spite of the fact that medically and even socially there may be negative outcomes from this behaviour (Mitchell, 1986; Stunkard, 1985). Along with the bingeing behaviour it is also necessary to go to extreme lengths to rid the body of the ingested food, for example by vomiting, or rigid dieting. Furthermore, these behaviours must be accompanied by particular cognitions, that is, self-depreciating thoughts after bingeing. These cognitions are generally considered to be a consequence of the individual's placing undue emphasis on body weight and shape, and a fear of being fat (e.g., Fairburn, Kirk, O'Connor, & Anastasiades, 1986; 1987). The reduction of bingeing and purging behaviours and the sense of being in control may relieve some of the guilt, shame, and despair felt by the sufferer (Hsu, & Holder, 1986), but unless his/her attitudes to weight and shape change, he/she may be constantly under the threat of relapse. Few studies to date have long term follow-ups (notable exceptions being Fairburn, O'Connor, Anastasiades, in preparation, cited in Fairburn, 1988a), and even fewer have components dealing specifically with relapse prevention. For a condition which follows a cyclic pattern often over long periods of time, this is an unfortunate oversight.

Unlike the sufferers of many disorders categorised in the DSM-III, the bulimic is not a societal misfit. Typically, the bulimic is female, of average weight, white, middleclass, well-spoken, educated and her abnormal behaviour is carried out in secrecy (Bruch, 1973; Herzog, 1982; Russell, 1979). Unless she is a young person referred for help by parents or teachers, she is likely to be self-referred. Although there are a number of possible medical problems associated with bulimia, the literature suggests that she is not likely to be so concerned about medical problems which may arise as a result of her behaviour, or even the behaviour itself, but rather about the feelings of loss of control, despair, and anguish that accompany them, and the constant battle of wills between her desires to be thin (or at least avoid becoming fat) and her compulsions to binge (e.g., Weiss & Ebert, 1983; Johnson, Connors, & Tobin, 1987). It is these cognitions that intrude on her everyday life and in extreme cases make all other considerations inconsequential.

Although control of the behaviours may bring temporary relief, as already suggested this control may be short-lived. Further, one could ask whether it should

be considered normal to control food intake as many researchers assume is a necessity for the sufferer of bulimia. One would expect that a normal healthy adult would follow a period of overeating, for example, a dinner party, with the consumption of less food for a day or so, not because of a deliberate decision to do so, but because he/she feels less hungry. He/she certainly would not exclude certain tempting foods from his/her house, nor would he/she count calories, nor write down everything he/she eats, nor make sure he/she is not alone, and therefore at risk.

None of these things are necessarily incorrect to include in a treatment programme, but they should not be seen as the end point of interventions.

A Change in Emphasis

In a review of cognitive behavioural treatments Laessle et al. (1987) have summarised success rates in terms of frequency and abstinence/non-abstinence of bingeing and purging behaviours. Only a handful of studies have attempted to monitor the cognitive components of the disorder (e.g., Fremouw & Heyneman, 1985; Fairburn & Cooper, 1982; 1986), although others have noted in passing an improvement in global measures of depression, anxiety, and self-esteem (e.g., Johnson, Connors & Tobin, 1987; Johnson-Sabine et al., 1984; Yates & Sambrailo, 1984). Over the last several years, it has been increasingly suggested that cognitions play a big part in the continuation of the binge/purge cycle, and not only cognitive interventions but also behaviourally oriented interventions have begun to include cognitive components. However, for the most part these components relate directly to the binge/purge behaviours, and inclusion of the components has been for the express purpose of lowering the frequency of the aberrant behaviours rather than changing cognitions as an end in itself.

Just as it was previously of interest to note whether behavioural treatments for bulimia changed cognitions (Giles, Young & Young, 1985; Halmi, 1985), it may now be pertinent to ask whether a global cognitively-based intervention might, by altering cognitions, also bring about the desired behavioural change.

Such an intervention, one based on cognitions, and not focused specifically on those surrounding bingeing/purging or other food related behaviours, would offer the following advantages if successful.

- In many cases, those presenting with bulimia are already likely to have had a long history of failures associated with their bulimic behaviours. Some may have undergone treatment for the condition previously which has been unsuccessful, or only partially or temporarily successful. Self-efficacy is

therefore likely to be low. However, focusing on less salient areas, for instance assertiveness, may help to improve self-efficacy without placing the individual in a threatening win-lose situation.

- Such an intervention is likely to be less aversive and therefore one would expect lower attrition rates.

- Because of its generalised nature such an intervention might lend itself to a cost-effective group situation, with only a minority requiring additional individual sessions.

- Skills learned would be generalisable over a number of different situations, for example, problem-solving, stress-management, social skills and so on. Any deficits in these areas triggering or exacerbating the bulimia would be decreased. That is, one could assume that such an intervention has targeted the cause(s) rather than the symptoms, bingeing and purging behaviours. (It should be noted that cause(s) here refer to those of an ongoing nature.) This would alleviate any recourse to controlling the behaviours with its associated risk of relapse.

- Such an intervention could set the stage for continuing change in the cognitions and behaviours of the individual. It may be unrealistic to expect profound changes to take place in the short time offered by many treatments, so it is desirable that these changes continue after treatment has been terminated and the support and guidance of the therapist has been removed.

- It would help to provide an 'immunisation' against societal pressures for women to be thin (Garner et al., 1980).

- Such an intervention would be easily adaptable to cater for non-clinical populations, that is those who are not so far along the 'eating problem' continuum but who nevertheless focus on food-related behaviours in their day-to-day lives.

Finally, if such an intervention were successful it would support the theory that bulimia is primarily a cognitive disorder, and thus provide direction for further research.

2

Status of Cognitive-Behavioural Treatments circa 1988

Before citing individual studies of treatment for bulimia nervosa[1] it is important to note the following considerations. First, the differing subject samples make it difficult to compare the relative efficacy of different treatments: for example, a treatment given to a college population versus that given to a group of patients with sufficient medical or psychiatric conditions to require hospitalisation. Second, studies have varying criteria for acceptance into the programme. In extreme cases as many as 60% are eliminated (Lacey, 1983). Third, few studies include treatment details making them difficult to replicate. For those with clearer guidelines for treatment, little or no attempt appears to have been made to ensure that therapists follow the treatment advocated. Only one detailed manual has been available to date (Fairburn & Cooper, 1984, revised 1989, in press).

Until the 1980s most studies were conducted using only one or two subjects (e.g., Kenny & Solyom, 1971, cited in Rosen, 1987; Linden, 1980). In the first part of this decade, waiting-list control designs were introduced. 'No treatment' or 'placebo' designs are difficult to devise in psychological treatment (Parloff, 1986). Factors such as the instillation of hope, therapist contact and a credible rationale, may well be some of the most important aspects of a successful treatment. It has been consistently found that levels of general psychopathology and severity of bulimia do not diminish for members of the control group while individuals undergoing treatment do tend to improve (Lacey, 1983; Lee & Rush, 1986; Freeman, Sinclair, Turnbull, & Annandale, 1985; Leitenberg, Rosen, Gross, Nudelman, & Vara,

[1] In USA this was renamed bulimia nervosa (from bulimia) in 1987 (refer to Appendix A ,page 68.

1989; Fremouw & Heyneman, 1985). This has provoked a suggestion (Fairburn, O'Connor, Anastasiades, in preparation, C.G. Fairburn, personal communication, April, 1989) that waiting-list controls should no longer be considered necessary.

In the latter half of the 1980s the most popular design has involved the comparison of two or more treatments. The reason for this was two-fold. First, it enabled two treatments to be compared in regard to their efficacy using the same population, and secondly, because of the early promising results of cognitive behavioural treatments for bulimia (e.g., Fairburn, 1981, 1985), it enabled some comparisons to be made between interventions, with cognitive behavioural treatment used as one of the experimental conditions. All the comparative studies with the exception of Russell et al. (1987) have used a CB (cognitive behavioural) control, many using the same CB treatment manual (Fairburn & Cooper, 1984).

Because CB treatments have been considered reasonably effective (Wilson, 1987; Garner, 1986a, 1986b, Anderson, 1987), much emphasis has been placed on refining and improving their techniques. How much justification there is for this is questionable since their effectiveness, in fact, has only been considered reasonable in light of the poor outcomes from the available alternatives. However, it should be noted that a good part of the current popularity of researching bulimia has been due to the development of these relatively effective treatment programmes. Previously those with eating disorders were considered unresponsive, unco-operative, and deceitful (Russell, 1979), and the disorder had a poor prognosis (Russell, 1979; Theander, 1985).

Bulimia was first included in the DSM-III as a disorder in its own right in 1980, and research on the disorder is still in its infancy. Little is known of the etiology of the disorder and studies to date have been of more practical help than theoretical interest (Fairburn & Cooper, 1988a). Evaluation of outcome has been poor, especially when follow-ups are brief, and findings have been inconsistent. Some studies which have included follow-ups have found that further improvements have been made after completion of treatment (e.g., Fairburn, Kirk, O'Connor & Cooper, 1986; Wilson, Rossiter, Kleinfield, Lindholm, 1986), but in many studies a deterioration has been noted (Wilson, 1988; Kirkley, Schneider, Agras & Bachman, 1985). The inclusion of a follow-up is therefore an important consideration, especially in comparative designs since a different picture of outcome may emerge by follow-up. Bearing these considerations in mind, a brief review will be given of treatments to date.

2.1 Pharmacological Treatments

A number of types of drugs have been used in the attempt to alleviate the 'symptoms' of bulimia, with the most promising of these being antidepressants. Pope, Hudson, Jones, and Yurgelun-Todd (1983) have advocated the concept that antidepressants decrease the depressive moods that may trigger bingeing episodes. This has yet to be empirically validated but it is clear that antidepressants have a favourable response, at least in the short-term (Pope et al., 1983; Mitchell & Groat, 1984, 1986; Hughes, Wells, Cunningham & Ilstrup, 1986; Agras, Dorian, Kirkley, Arnow & Bachman, 1987). A number of placebo-controlled, double-blind studies have shown good results with total remission of symptoms obtained with some patients (e.g., Walsh, Stewart, Roose, Gladis & Glassman, 1984; Hughes et al., 1986; Agras et al., 1987). However, no follow-up studies were carried out. In the only study with a systematic follow-up, it was found that few of the patients were able to discontinue medication without their condition deteriorating, and some patients required as many as four different antidepressant drugs (Pope, Hudson, Jonas, Yurgelun-Todd, 1985). In a meta-analysis of studies before 1985, Laessle et al. (1987) found that 'effect-size' or reduction in 'binge-purge' frequency was greater using other treatments, notably cognitive-behavioral treatment. However, few of the studies employed a direct comparison and meta-analysis as a method has been questioned (Wilson, 1985). Preliminary findings from a large comparative design study have found that although imipramine does produce benefits, these are not as great as cognitive-behavioural treatment. Furthermore, imipramine, when used in conjunction with CB treatment, does not increase the benefits to be had by CB treatment alone (Mitchell, Pyle, Eckert, Hatsukami, Pomeroy, & Zimmerman, 1988, cited in Fairburn, 1988a). No follow-up data has yet been obtained.

2.2 Behavioural Treatment

The hallmark of behaviour therapy has been its focus on the behavioural manifestations of any psychopathology. Thus, behavioural treatment to date has concerned itself almost exclusively with bingeing and vomiting behaviours in bulimia.

Using an aversion paradigm, Kenny and Solyon (1971, cited in Rosen, 1987) successfully treated one patient by administering an electric shock to the finger while she was imaging the sequence of eating and vomiting.

Nearly a decade later, Linden (1980) also successfully treated one patient by combining several behavioural techniques. These included scheduling three meals daily plus snacks and prescribing yoga and social assertion as alternative responses

to binge eating. Stimulus control methods were used to limit access to food, (for instance, high calorie food was removed from the house), access to the refrigerator was restricted and food was served to the subject in lieu of self-service. Vomiting was eliminated after seven sessions and with only several exceptions this was maintained for the 6-month follow-up.

These initial psychological treatments were based on an anxiety disorder model (e.g., Johnson & Brief, 1983). Two studies were conducted to test the effectiveness of relaxation as a treatment for bulimia (Mizes & Lohr, 1983, 1986). Each study was a single subject design. The interventions were protracted, lasting 22 and 32 weeks respectively. Results were modest, with the first patient relapsing and still vomiting at the 6-month follow-up, and the second improving after treatment, but no follow-up data was reported.

Based on an obsessive-compulsive model, Welch (1979, cited in Rosen, 1987), in a single subject design, had a subject monitor obsessional thoughts and increasingly delay each step in the vomiting ritual. At 11-month follow-up, the patient was abstinent from vomiting. Long and Cordle (1982) had similar success with one of two subjects, as did Grinc (1982) with one subject, using stimulus control procedures. The latter treatment also included sessions focused on cognitive restructuring of irrational beliefs and was therefore not a strictly behavioural treatment.

One of the most popular of the behavioural treatments has been that advocated by Leitenberg, Rosen and colleagues (1982; 1984; 1985; and 1986, cited in Fairburn, 1988a). Based on the proposition that vomiting is an escape response from the anxiety of overeating, the focus of the treatment is on controlling the vomiting component of the binge/vomit cycle. Typically, the patient is required to eat to the point of having the urge to vomit and is prevented from doing so by the therapist. During these long sessions, the therapist concurrently conducts a cognitive restructuring component. Although there is little empirical support for the notion that bulimia is a cognitive disorder (Rosen, 1987), most behavioural treatments now include at least some cognitive components, and the importance of cognitive distortions for the maintenance of the disorder is widely accepted (Polivy & Herman, 1985; Fremouw & Heyneman, 1985; Polivy, Herman, Olmsted, & Jazieski, 1984; Garner, 1986b). Advocates of the behavioural treatments have suggested that there are advantages of incorporating these verbal therapies into an *in vivo* exposure and response prevention situation (Rosen, 1987). However, research has not shown this to be the case. An uncontrolled study of 34 bulimic patients by Giles, Young and Young (1985) used similar techniques. After treatment 65% of the subjects had at least a 50% decrease in vomiting. However, the number of subjects who were abstinent from vomiting was small and the dropout rate was high. In a similar study

(Wilson, Rossiter, Lindholm, and Tebbutt, 1986), 50% of the 40 subjects were abstinent at completion of a lengthy treatment (16 sessions plus additional sessions when necessary). Of these 53% remained abstinent after one year (10 subjects). The dropout rate was 35%.

In the first controlled evaluation of cognitive-behavioural treatment with exposure plus response prevention (Ordman & Kirschenbaum, 1985), 10 subjects were put on a waiting-list after 3 sessions and were encouraged to practise eating at home without vomiting. Ten subjects attended an average of 15 individual treatment sessions. A 75% decrease in vomiting was shown by the treatment group versus a 29% reduction by the control group. However, only 2 of the treated subjects (10%) had stopped vomiting at completion. No long-term follow-up was conducted. The dropout rate in other studies has typically been at least 33% (Laessle, Zoettl, & Pirke, 1987) and the outcome has been modest.

Success rates measured in percentage decrease in vomiting are often misleading; for example, if a patient is vomiting 4 times per day, a 75% reduction means he/she is still vomiting daily.

The Leitenberg and Rosen group (1988, cited in Fairburn, 1988a) have conducted two studies to compare the relative effectiveness of different forms of ERP. No clinical differences were found when the *in vivo* experience occurred at the clinic; or at the clinic restaurant, and the patient's home. Wilson (1988, cited in Fairburn, 1988a) also compared ERP conducted at the clinic with home-based, self-administered ERP. Outcome was not impressive - 76% of the patients significantly reduced their binge-eating and vomiting rate, but by a nine-month follow-up the success rate had fallen to 43%. Sixty percent of the clinic-based patients relapsed during this period. Although there were no clear differences between the two approaches at the completion of treatment, at the nine-month follow-up the home-based group showed a lower relapse rate. This outcome was not consistent with the findings of an earlier study by the same group (Wilson et al., 1986).

To test the hypothesis that binge-eating in bulimia nervosa is more a consequence of vomiting than vomiting is a consequence of binge-eating, Leitenberg and colleagues included a CB treatment without ERP as one of the conditions (Leitenberg et al., 1989, cited in Fairburn, 1988a). Surprisingly, this treatment was as effective on almost every measure as the two ERP-based treatments. In an earlier study (Wilson et al., 1986), the reverse was found, that is, treatment containing ERP was superior to a CB treatment without ERP. One explanation of the discrepancy was Fairburn's (1988a) notion that the CB treatment used by Leitenberg and Rosen was more potent because it was mainly composed of behavioural procedures whereas that used by Wilson's group had been mainly verbal, and therefore perhaps relatively ineffective. In any case, it has not been adequately shown that treatment

involving ERP is superior. Furthermore, ERP is time-consuming for the therapist and aversive for the patients. It would appear that until further research indicates to the contrary, as a treatment, it has limited value. Wilson (1988, cited in Fairburn, 1988a) proposed that three subgroups of patients might benefit: Those who find it impossible to start eating regular meals; those who are unable to introduce avoided foods into their diet; and those who persist in vomiting even after average-sized amounts of food.

2.3 Cognitive Behavioural Treatment

Although CB treatments are the treatment of choice at present, as mentioned earlier there is little in the way of standardisation of procedures. Some CB treatments emphasise cognitive components such as cognitive restructuring, while others emphasise behavioural components. Yates and Sambrailo (1984) studied the relative efficacies of two short-term treatments (6 weeks). In the CB condition 12 subjects were trained in relaxation, assertiveness and thought modification. The other treatment ($n = 12$) was behavioural and focused on self-control of bingeing and vomiting behaviours, stimulus control and scheduled delay after bingeing. The combined results showed a 21% decrease in vomiting at the completion of treatment with 35% decrease at 6-week follow-up. Less than 30% appeared to show any improvement in bulimic behaviours and none were abstinent from vomiting at follow-up but there were improvements in depression, anxiety, and self-esteem. One study, still in progress, is investigating the relative short- and long-term efficacy of a CB treatment containing both cognitive and behavioural components, and a treatment consisting largely of behavioural procedures (Freeman, Dunkeld-Turnbull, Barry, & Henderson, 1988). At the end of treatment, the purely behavioural approach was not only as effective as a CB one but also the drop-out rate was lower (17% compared with 34%). However, since follow-up data are not yet available, it is considered too early to draw conclusions. In a similar study, Fairburn et al. (in preparation, 1988a) compared three conditions, a primarily behavioural therapy, a CB therapy, and an interpersonal psychotherapy (in press, cited in Fairburn, 1988a). Preliminary findings have suggested that, contrary to Freeman et al.'s study, the behavioural treatment was inferior to the CB treatment, both in the measures of outcome and drop-out rate (32% compared with 12%). However, the study is not yet complete and results at follow-up are crucial in such comparative studies. Long-term superiority of the CB treatment would support a cognitive view of bulimia nervosa since this view predicts that "for there to be complete and lasting recovery,

there should be change not just in these patients' behaviours but also in their attitudes towards their shape and weight" (Fairburn, 1985, 1988b, cited in Fairburn, 1988a, p 638).

During the last four or five years, the majority of the research of bulimia nervosa has concerned itself with isolating which are the effective components of CB treatments. However, as already suggested the emphasis on CB treatments may not be warranted.

Kirkley, et al., (1985) compared a group form of CB treatment with a non-directive group therapy. At completion of the sessions the CB results were superior, but at the 3-month follow-up the outcomes were similar with 77% and 78% of participants achieving a 60% reduction in frequency of vomiting (dropout rate, however, was higher in the non-directive group). Although these results were modest for both groups, the study does suggest that procedures other than CB ones may be as effective in alleviating the symptoms of bulimia nervosa.

A second study (Fairburn, 1985) used individual rather than group therapy to compare a CB treatment with an adaptation of an established form of brief psychotherapy. Although the CB treatment proved superior *all* patients improved substantially on all measures, and these improvements were maintained in the majority of cases over a four year period (Fairburn, in preparation, cited in Fairburn, 1988b). The only CB components the brief psychotherapy included were limited self-monitoring and some education.

As mentioned earlier, Fairburn et al. (1988) are at present comparing three interventions: a CB treatment, a primarily behavioural intervention and a form of 'interpersonal psychotherapy' which was an adaption of a brief psychotherapy for depression (Klerman, Weissman, Rounsaville, Chevron, 1984, cited in Fairburn, 1988a). This treatment "does not address the specific psychopathology of these patients: instead it concentrates exclusively on their mood and relationships" (Fairburn, 1988a, p.641). However, patients in this group improved over all measures including their levels of general psychopathology, and substantial changes in eating habits and attitudes to shape and weight. Although the study is incomplete with a number of patients yet to take part, and although follow-up data will be necessary before any conclusions can be drawn, the author considers this study represents a major breakthrough in research in the area. Figure (2.1) shows the initial results of Fairburn's study.

An important question arising from this study concerns the mechanisms by which change is achieved in each of these three treatments. Do they each have common characteristics such as therapist attention, credible rationale, hope, structure, increase in self-efficacy? If so, why have other studies shown less favourable

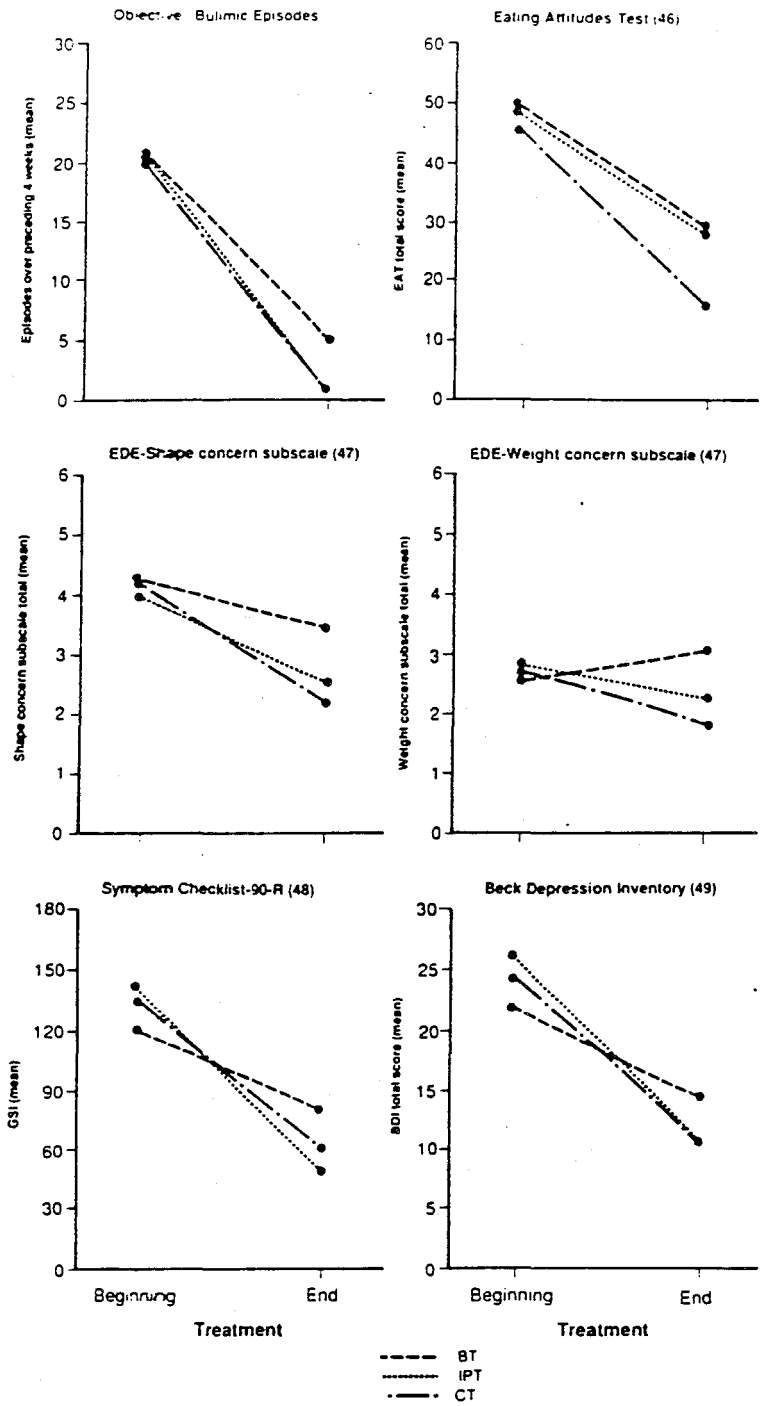

FIGURE 2.1: Changes in measures of specific and general psychopathology in 43 patients treated with behaviour therapy (BT), cognitive therapy (CBT) or interpersonal psychotherapy (IPT) (Fairburn, 1988(a)).

outcomes? One alternative is that in each of the treatments change may be mediated through different pathways. Fairburn (1988a) suggested that CB treatments appeared to change the patients behaviour and attitudes to shape, weight, and eating, thus bringing about a change in the more global measures, such as depression, whereas with brief psychotherapy, changes across all measures appeared to be mediated through an effect on negative self-evaluation. Fairburn suggested that an increased sense of self-esteem and competence lessened the intensity of their tendency to evaluate themselves largely in terms of their shape and weight. This, in turn, appeared to lead to a change in their eating habits. This proposal is supported by the findings of an earlier study (Fairburn, Kirk, O'Connor, Anastasiades & Cooper, 1987) that the level of patients' self-esteem prior to treatment was the strongest predictor of outcome regardless of the form of treatment, or the pre-treatment level of depression, with those patients having low self-esteem improving least.

2.4 Group Therapies

The majority of studies employed or conducted treatment on an individual level but a small number of studies involving group treatment have been made.

Connors, Johnson, and Stuckley (1984) conducted a group treatment with components of education about body-weight regulation, and cultural factors in body image, along with behaviour modification including meal regulation, scheduled reduction in vomiting behaviours, planning alternate activities in response to urges to binge-eat, assertiveness training, and relaxation. The reduction in vomiting at post-treatment and 10-week follow-up was about 70% but had decreased to 15% at follow-up. There were improvements on measures of self-esteem, eating attitudes, and depression. A similar study (Schneider & Agras, 1985) included cognitive restructuring of faulty beliefs related to binge eating and vomiting, stimulus control, delaying binge-eating, and practice eating forbidden foods at home. Problem solving, assertiveness training and relaxation were also included. Treatment lasted 16 weeks. At post-treatment there was a 90% reduction in vomiting with 54% abstinent. After six months there were some cases of relapse. The 38% abstinence at follow-up appeared to include 2 of the 13 subjects who did not vomit from the outset, i.e., 3 of the 11 vomiters (27%) were no longer vomiting at a 6-month follow-up.

In a controlled study of group treatment (Lacey, 1983), patients were asked to sign a contract that they would follow a structured diet of limited carbohydrate intake and three meals per day. Another contract committed them to eventually stop

binge-eating and vomiting. Nineteen percent of the volunteers refused treatment at this stage. Treatment focused on identifying alternative methods for dealing with interpersonal stress and psychodynamically oriented therapy for parental conflicts and sibling rivalry. Within one month after treatment 83% of the patients were abstinent and after one year only 8 of the original 30 subjects (including 15 in a waiting-list control group who subsequently underwent treatment) had bulimic episodes. This is an unusually high success rate. Interestingly, depression *increased* rather than decreased as bulimic behaviours subsided.

Lee and Rush (1986, cited in Rosen, 1987) conducted CB group therapy with both vomiters and non-vomiters. Twelve sessions were conducted over 6 weeks. The major emphasis of the intervention was: education regarding weight regulation; cognitive restructuring of familiar beliefs regarding weight and eating; relaxation and increasing activities out of the home. Four subjects of fourteen (28%) dropped out of treatment. At 3–4 months follow-up, only 2 subjects (14%) were abstinent from vomiting in spite of an overall 80% reduction in the frequency of vomiting. However, evaluation is confounded by the inclusion of both vomiters and non-vomiters in the sample. In another study involving a short-term group treatment programme (Wolchik, Weiss, & Katzman, 1986), the focus was put on the psychological problems of bulimics as opposed to attempting to control eating and vomiting behaviours. Eleven subjects underwent seven group and two individual sessions. Included in the treatment were cognitive restructuring of beliefs about food, eating and weight issues as well as negative thoughts regarding self-worth and coping mechanisms, assertiveness training and self-control of negative emotions. No behavioural procedures relating to binge-eating or vomiting behaviours were included. Although vomiting decreased by an average of 60% at 10-week follow-up, none of the 8 regular vomiters were abstinent at post-treatment and only 2 (25%) were abstinent at follow-up. Three subjects did not decrease the frequency of vomiting behaviours. Improvements were noted in self-esteem, depression, and body image.

In a study to compare CB interventions with a non-directive group therapy (Kirkley, et al., 1985), 28 subjects were randomly assigned to either a group treatment programme modelled after that described in their earlier report (Schneider & Agras, 1985), or to a non-directive condition where they were not given specific instructions to alter behaviours. Although the results of CB treatment were superior post-treatment, the two conditions did not differ significantly in the reduction of vomiting behaviour at 3-month follow-ups. However, 38% of the CB were abstinent compared to 11% of the non-directive condition. Twenty-three percent of the CB condition relapsed at follow-up.

With the exception of the Lacey study (1983), outcomes for group treatments

have, at best, been modest. Drop-out rates and relapse rates are high at short-term follow-ups. No long-term follow-ups have been carried out in group studies to date. Neither have there been any studies in which subjects are allocated to either group or individual treatment of the same form.

In conclusion, the most promising of available treatments to date has been some form of CB therapy. However, it is unclear which components are necessary to maximise success. Some studies, (e.g., Fairburn, in preparation, cited in Fairburn, 1988a) have indicated that treatments with no specific CB components may yield similar results. The role of drug treatment has yet to be shown to be of long-term benefit. In fact, the majority of studies have follow-ups which are much too short to provide more than tentative indications of value. Few studies have been able to predict outcome from the original data. In part, this is because of small sample size. The studies for the most part have added little to our knowledge of the etiology of the disorder, and results are often inconsistent. There may be subgroups of those suffering from bulimia who would profit more from one form of treatment than another. For example, Fairburn (in press) suggested that patients who are over- or under-weight, those who have multiple addictive behaviours and those in whom there is significant associated personality disturbance may have special needs.

3

Rationale and Hypotheses

It is widely accepted that eating disorders such as bulimia are multi-dimensional. As a group sufferers tend to be low in self-esteem (Johnson & Larson, 1982; Fairburn, 1981) assertiveness (Garner, 1986b), and high in depressive symptoms (Hudson, Pope, Yurgelun-Todd, Jonas, & Frankenburg, 1987; Johnson-Sabine, Wood, & Wakeling, 1984; Johnson & Larson, 1982), but aside from the manifestations of the disorder, they may be more remarkable because of their differences than because of their similarities. To date, no attempt at matching client to treatment has been made and consequently for a particular intervention a reduction in the frequency of bulimic behaviours of 50–70% for the majority of subjects is often considered a success. What should constitute a good treatment for bulimia nervosa? A number of criteria must be satisfied. First, the rationale must be credible, particularly for individuals who have suffered bulimia for a number of years and have undergone a number of alternative treatments. Second, participation in the programme must be non-aversive, or at least, not so aversive that a dropout rate of 30–40% might be expected. Third, a change in the beliefs, attitudes and cognitions of the sufferer must take place. Fourth, it is desirable that ultimately at least some of the behaviours typical of bulimia, such as purging, be eliminated. Fifth, the subject must be 'immunised' against perceived pressures to lose weight and/or measure his/her worth in terms of weight and shape in order to reduce the likelihood of bulimic behaviours in the future. Sixth, the individual should perceive himself/herself as playing the major part in the change that takes place, thereby increasing self-efficacy. Finally, treatment should be cost-effective.

Programmes which seek to change cognitions, namely cognitive and cognitive-behavioural programmes, are relatively new (e.g., Fairburn, 1981; Fairburn & Cooper, 1984; Garner, 1986a), and are gaining impetus because it is increasingly

recognised that long-term maintenance of improvement requires such a change. However, this is still seen as secondary to reducing the behaviours themselves. Consequently, success rates continue to be measured in terms of frequency of binge/purge behaviours. It is important to note that, just as severity of bulimia at pre-intervention is not a good predictor of outcome, neither can severity of bulimia, as measured by frequency of bingeing and purging behaviours, be considered a good predictor of long-term outcome.

Some treatments are now including components of relapse prevention (Marlatt & Gordon, 1986, Marlatt & George, 1984; Freeman, Beach, Davis & Solyom, 1985). The majority of these stress the necessity to regain control by the reuse of stimulus control, self-monitoring, and other techniques. Few contain educative components to assist the individual become aware of the insidious social pressures that may impinge on women's eating, and how to avoid being influenced by them. This is surprising when sex differences in attitudes towards body weight, food and eating are so well documented (Chaiken & Pliner, 1987). Females report greater dissatisfaction with their bodies and diet more frequently in spite of the fact that it is men who are more likely to be overweight as adults (Rodin, Silberstein, & Streigel-Moore, 1985). Chaiken and Pliner (1987) found that a woman's food intake and body weight influenced others' perceptions of her femininity, and results of their study suggest that women may be motivated to restrict their food intake in order to enhance their self-identity. This, in turn, could give rise to a chronic pattern of dieting and bingeing behaviours characteristic of bulimia (Garfinkel & Garner, 1982). While accounts of the etiology of bulimia have not overlooked the possible role of sociocultural variables (e.g., Rodin et al., 1985; Striegel-Moore, Silberton, & Rodin, 1986), few treatments of bulimia have addressed this issue (an exception being Katzman & Wolchik, 1984).

In regards to the cost-effectiveness of treatments of bulimia, the least costly in the short term is drug therapy. However, long-term results for the efficacy of drug treatments are lacking. A group treatment would be cost-effective if the outcome was as favourable as individual treatments. The data suggests this is not the case (e.g., Garner, Fairburn, & Davis, 1987). Dropout rates have been high and success rates modest (e.g., Kirkley et al., 1985). To date, there have been no comparisons of a group and individual version of the same treatment programme. Many of the treatment procedures, such as education or assertiveness training, could be introduced more efficiently during group therapy. Group therapy may serve to reduce the sense of shame and isolation felt by sufferers of bulimia, with those benefiting from sessions serving as role models for other group members. It may also be more possible for members of a group to formulate ideas and concepts themselves rather than have an expert expound on them, thereby raising self-efficacy. Furthermore,

the group situation offers an opportunity to practise those social skills which are found to be lacking in those with eating disorders. However, to keep dropout rate low, participation would need to be as non-threatening as possible, preferably with no failures, no confrontations, no pressures to complete assignments, and above all, the leader must be perceived to hold all members of the group in positive regard.

3.1 Which comes first?

Fairburn and Garner (1986) and others (e.g., Chiodo & Latimer, 1985; Rosen, 1987) have remarked on the low self-esteem found in women with bulimia and have observed how successful treatment brings about an increase in self-esteem. Similarly, improvements are noted in levels of anxiety, depression, and social adjustment (e.g., Ordman & Kirschenbaum, 1985; Andersen, 1987). There appears to be an underlying assumption that low self-esteem, anxiety, depression and poor social skills are *secondary* to bulimia. In fact, no empirical evidence has pointed to this. In a controlled study of the prevalence of affective and other psychiatric disorders in bulimic patients by Hudson, et al. (1987), the results suggested a phenomenologic relationship between bulimia and major affective disorders. A 67% rate of major affective disorders was found in 70 bulimic subjects with 61% reporting a history of anxiety disorders, and 39% reporting substance abuse. The affective disorder preceded bulimia in approximately one third of the subjects, coincided with onset of bulimia in one third, and followed the onset of bulimia in one third of the cases. If focusing on bulimic behaviours can bring about a positive change in other aspects of a person's psychology, can focusing on these aspects, a less aversive procedure, bring about positive changes in the condition of bulimia?

3.2 A Functional Model of Bulimia

Underlying all forms of treatment of bulimia is the notion that bulimic behaviours are inherently bad or maladaptive, and therefore must be controlled. Fairburn and Cooper, (in press) claim that the eating problem will constitute an Archille's heel since eating and/or vomiting are likely to remain her response to stress. Contrary to this, a functional model of bulimia[1] would hold that the bulimic behaviours may actually be a relatively harmless way of coping with situations and/or feelings which would otherwise be beyond the person's ability to cope with. The function

[1]The functional model proposed is not intended to throw light on the etiology of bulimia, but rather as a basis for an intervention programme.

of the behaviour(s) at the time of onset may be different from the ongoing functions. What functions? And why bulimia? The second of these questions will be addressed first. It appears that weight concerns and dieting are so pervasive among females in western societies today that they have become normative (Rodin, et al., 1985; Garner, Garfinkel, Schwartz, & Thompson, 1980). An increasing percentage of women feel too fat regardless of their actual weight (Huon & Brown, 1985; Polivy & Herman, 1985; Cash & Brown, 1987) and engage in repeated dieting efforts (Streigel-Moore, Silberstein, & Rodin, 1986). At least this component of the bulimic picture is condoned and even actively encouraged by society. Bulimia and its sister disorder, anorexia nervosa, could be seen as extreme points on a continuum ranging from those who are unconcerned about weight and eat without restraint, through to those who have 'normative discontent', to those presenting with bulimia (Rodin et al., 1985; Polivy & Herman, 1987). It may be that there are biological, developmental, sociocultural and psychological reasons why any one individual has a greater propensity to move towards the bulimic end of the scale. All that is needed to tip the balance may be a payoff from one initial dieting attempt. This may be in the form of self-reinforcement for being in control, or achieving something tangible, in this case, weight-loss. It may win compliments from others, or even parental concern. A positive reinforcement for one person is different from that of another. There are many, many possible perceived gains from dieting attempts, or being thin in today's social milieu. Bulimia has been found to be preceded by dieting in the majority of cases (Polivy & Herman, 1985; Williamson, Kelley, Davis, Ruggiero, & Veitia, 1985).

Food deprivation, for whatever reason may result in bizarre behaviours, even in normal, that is, not psychopathologically disposed individuals (Keys, Brozek, Henschel, Mickelsen & Taylor, 1950). These behaviours include bingeing, constant thinking about food, lingering over meals and/or eating very quickly, hoarding food and eating unpalatable combinations. Bingeing is a physiological response to dieting (Polivy & Herman, 1985) whatever other secondary gains are to be had. For an individual who has been attempting to restrict his/her food intake, especially if there are rewards from doing so, bingeing can be devastating. Guilt, shame, feelings of loss of control, and possibility of further episodes with the fear of gaining weight will, in turn, lead to greater efforts to control food intake. Thus a vicious cycle has begun. There are other factors which make the situation even more complex. For example, the relationship between bingeing, dieting and purging behaviours with depression is far from clear (Johnson, Connors & Tobin, 1987). A review of studies examining the effect of weight reduction on depression, Smoller, Wadden and Stunkard (1987) found that many studies indicated that weight reduction was accompanied by a high incidence of affective disturbance, ranging from

simple dysphasia to clinical depression and psychosis (e.g., Robinson & Winnik, 1973; Fairburn & Cooper, 1984; Fairburn et al, 1985). However, results from other studies concluded that weight reduction appeared to improve mood (e.g., Wing, Epstein, Marcus, Kupfer, 1984). Smoller et al., (1987) concluded that the type of assessment used and treatment modality for weight loss were the best predictors for positive and negative changes in affect. However, it is likely that there are profound individual differences, and perhaps even differences for each individual dependent on other factors, such as stress levels. There is some evidence that bingeing itself temporarily decreases both depression and anxiety (Fairburn, 1984; 1987) although the resulting psychological reaction to loss of control over eating is likely to include features of depression, anxiety, social withdrawal and impaired concentration (Cooper & Fairburn, 1986). The problem is further exacerbated when purging behaviours (vomiting and laxative use) with concomitant physiological complications are added to the repertoire of the sufferer. Purging behaviours are now commonly considered to be secondary to the bingeing behaviours (Herman & Polivy, 1985). As well as relieving the discomfort caused by bingeing, the individual is able to avoid (he/she believes) inevitable weight gain. In the behavioural model, the use of vomiting then releases inhibitions against bingeing and as a result bingeing behaviour increases in frequency. It is at this point in the cycle that behaviourists attempt to intervene with ERP (e.g., Rosen & Leitenburg, 1985). Cognitive-behavioural therapists typically attempt to bring the whole range of behaviours under control by the use of stimulus control, prescribed meals and snacks, the use of cognitive coping skills to combat urges to binge and/or purge, and cognitive restructuring of distorted beliefs (e.g., Fairburn, & Cooper, 1984; Fairburn & Cooper, in press). It is possible that the successful component of CB treatment is that in attempting to develop the individuals' self-control of eating by prescribing regular meals, first the restriction of food intake, and thus, many of the secondary cognitions and behaviours typical of bulimia are diminished. If, in combination with this, the individual is convinced not to diet, that is, by changing cognitions about weight and body shape, one might expect bingeing and purging behaviours to disappear. However, if dieting, bingeing or purging has an important function in the person's life, that is secondary gain, then the behaviour will persist.

This leads us to the second question, what functions might the eating disorder fulfil in the individual's life?. The most obvious of these have already been discussed. For dieting, these include positive feedback from others, self-esteem from the perceived control of food intake, and possibly relief from negative affect. The hoped-for result of the dieting, being thin, is often associated with being more successful, more feminine, more attractive (Chaiken & Pliner, 1987), and happier.

Furthermore, it is seen as a way of avoiding being overweight, a condition associated with lack of success, laziness, lack of self-control, unattractiveness, lack of grooming, and a lack of femininity (Chaiken & Pliner, 1987). Bingeing, as mentioned, is the normal physiological response to starvation, even 'mini-starvations' typical of bulimia, in which the individual does not eat breakfast or lunch in order to 'save-up' for later, or, as a punishment for bingeing the previous night. As well as this, for some individuals, food may represent maternal love, nurturance or security, and for others, a pacifier or way of coping with pain whether physical or psychological. Food, especially carbohydrate is thought to have a depressive effect on emotions (Herman & Polivy, 1975, 1980; Morley & Levine, 1980). If this is so, then any emotions which are difficult for the individual to cope with, such as depression, anxiety, grief, anger, fear, loneliness or helplessness may be directly alleviated by eating large quantities of high-carbohydrate foods. However, whether or not this is the case, a different coping mechanism might involve 'switching' the mind-set away from the immediate feelings/problems/situations and onto the more familiar, less aversive cognitions associated with weight, body shape, and eating behaviours. Imagine, for example, a woman after being physically abused by her husband, optimistically planning yet another diet, or another, faced with a long, lonely evening, planning a binge. Any negative feelings towards others or the situation may be transferred to her new behaviour. She is likely to feel more comfortable having self-depreciating thoughts than she would be confronting others. And remarkably, in the most depressing life situations, the sufferer of bulimia is likely to complain that the biggest problem in his/her life is that he/she binges. Typically, those with eating disorders are non-assertive and poor in social skills (Hood, Moore, & Garner, 1982). With little perceived power to change their lives, such individuals attempt to control their food intake. This behaviour is reminiscent of the self-destructive behaviours seen in animals in Seligman's learned helplessness paradigm (Seligman, 1974).

3.3 Control

Control is a word frequently used by those with bulimia. 'My eating is out of control', 'I'm out of control', and 'my life is out of control'. Control is also a word very often used by therapists who attempt to enhance the patients' control over eating (Fairburn & Cooper, in press). In fact, helping the individual regain control over food-related behaviours is central to most therapies for eating disorders. An intervention based on a functional model of bulimia, however, would render control unnecessary. Food, shape and weight would become non-issues if the functions

served by bulimic behaviours were either made redundant or served by other more appropriate and desirable behaviours. Such an intervention would attempt to aid the discovery of the positive functions of the behaviour by the individual. Realisation that the behaviours he/she found so abhorrent are in some way useful to him/her may be sufficient to bring about a change in cognitions. Encouragement to use these behaviours until such time as he/she is comfortable with other alternate behaviours (such as assertiveness) is likely to lessen the fears of failure, percieved loss of control, and the fear of the unknown, and encourage the reduction of the guilt, shame, and sense of worthlessness felt by the individual. Ironically, this may actually *lessen* the behaviours, and more importantly, at this stage, prepare the individual for learning or relearning the skills he/she lacks. The emphasis is on *increasing* the behaviours in his/her repertoire rather than on *decreasing* them as is the case in many therapies. Nor, in this model is lapse or relapse an issue. If an individual finds himself/herself dieting, bingeing, or focusing a good deal of attention on his/her weight or shape, it can be seen merely as a signal that something is going on which needs attention. He/she may choose to confront with the underlying problem or bide his/her time, such as in the case of grief or separation.

3.4 Self-efficacy

The development of self-efficacy (Bandura, 1977) is central to an intervention based on a functional model because one important function of bulimia is as a coping mechanism in threatening situations, or at times of stress. The social learning view holds that potential threats activate fear largely through cognitive self-arousal (Bandura, 1969, cited in Bandura, 1977). A perceived increase in self-competence can lower susceptibility to self-arousal and therefore render the individual less prone to generate frightening thoughts in threatening situations. In Bandura's model of self-efficacy, expectations of personal efficacy are derived from four principal sources of information. These are: performance accomplishments, vicarious experiences, verbal persuasion, and physiological states (Bandura, 1977). All four modes of influencing and increasing self-efficacy can be used in group therapy. Note should be taken that efficacy expectations vary from individual to individual on a number of dimensions, namely, magnitude, generality and strength, and that this has important performance implications. Self-efficacy can be initially increased through a rapid mastering of a number of simple tasks[2] (see handouts, Appendix C on page 94) in an environment where individuals can perform successfully despite their incapacities. Group members who can perform the tasks at hand may be useful role

[2]Note that these tests should not involve food, weight or shape related tasks.

models, especially if they initially find the task difficult themselves. A credible rationale must be presented with each set of tasks, so that physiological arousal, instead of remaining a cue to eat, can be increasingly interpreted as fear, excitement, anger, or whatever, and these emotions used in turn as cues to try out new behaviours. It is important to stress that there is no such thing as 'failure' in the intervention, just 'successes' and 'opportunities to learn more'.

3.5 Cognitive Restructuring

Most CB therapies for bulimia include a component of cognitive restructuring. The majority of these, however, focus on thoughts and beliefs concerning the bulimic behaviours, for example, weight and shape. A much broader examination of words, and the use and power of words, especially in 'self-talk' may be useful. An explanation of the formation of belief systems and attitudes at both individual level and societal level may suggest the possibility that these may be changed at will (refer to Appendix C, on page 94).

3.6 Summary and Hypotheses

A functional model has been advocated as a basis for the formulation of an intervention for bulimia. The functions of the entire syndrome as well as the individual behaviours, that is, dieting, bingeing and purging, vary from individual to individual, but are likely to include the use of bulimic behaviours as mechanisms for coping with threatening situations and/or feelings (e.g., Bruch, 1973). If the individual develops appropriate alternate skills, the bulimic behaviours might be expected to diminish. Thus the emphasis of an intervention of the type used in this study is placed on increasing rather than decreasing the individuals' repertoire of behaviours. There were four major hypotheses regarding such an intervention. The first was that the treatment groups employing this type of treatment would improve significantly over a control group on a measure of bulimia. The second was that the treatment outcome would be dependent on the duration of bulimia; therefore, those who had suffered the disorder for a shorter time would benefit most. The third hypothesis addressed the two main categories of bulimia, binge/purge and binge/diet (Polivy, 1976; Polivy, Herman, & Walsh, 1978; Dykers, & Gerrard, 1986), with the null hypothesis that both groups would benefit equally from intervention. The final hypothesis was that improvements in measures of wellbeing, self-esteem and anxiety would be accompanied by improvements in the measures of bulimia. The study also examined the possible relationship between depression and bulimia.

4

Method and Design

4.1 Subjects

Subjects answered an advertisement in a daily newspaper. Males, those living out of town, those currently undergoing treatment for bulimia and those presenting with severe psychosocial problems were excluded. Of the remainder, some were only prepared to have a telephone interview, and some only to take part in the individual assessment sessions. Those who met the *Diagnostic and Statistical Manual of Mental Disorder* (DSM-III; America Psychiatric Association, 1980, page 68) criteria for bulimia as determined by a standardised eating behaviour questionnaire were matched across three groups. Their mean age was 31.97 years (range = 19.3–41.1 years).

Participants reported first dieting at a mean age of 16.33 years and vomiting at a mean age of 22.5 years. On average the participants had been dissatisfied with their weight or shape for 16.12 years.

Fourteen subjects or 58.3% reported having a mother with an eating problem, 12% a father, 45.8% a sister, and 12.5% a spouse.

4.2 Measures

All participants completed a battery of questionnaires prior to the first individual assessment session. These were as follows:

1. General Information Questionnaire
2. The Revised Delusions-Symptoms-State Inventory (DSSI-R; Bedford & Foulds, 1978) see Appendix D, page 117). This self-report checklist covers a

wide range of psychiatric symptoms and is designed as an aid to psychiatric diagnosis.

3. The Bulimia Test (Bulit; Smith & Thelen, 1984). The Bulit, a 32-item, self-report, multiple-choice scale, was developed specifically to assess the symptoms of bulimia based on criteria of the DSM-III. The Bulit has been found to be a reliable and valid predictor of bulimia (Smith & Thelen, 1984), and has demonstrated superior predictive validity for bulimia than less bulimia-specific measures such as the Eating Attitudes Test (Garner & Garfinkel, 1979; Garner & Garfinkel & O'Shaughnessey, 1985), the Eating Disorder Inventory (Garner, Olmsted & Polivy, 1983), and the Binge-eating Inventory (Hawkins & Clement, 1980);

4. Affectometer 2, a 40-item self-report questionnaire of psychological well-being. Positive and negative affect are each measured by 20 Likert-scale items (Kammann, 1981);

5. The Beck Depression Inventory, shortened form, a 13-item self-report inventory of depressive symptoms (Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961);

6. Rosenberg's Self-esteem questionnaire, a 10-item measure of self-worth (1979);

7. The Spielberger State-Trait Anxiety Inventory (STAI), a 40-item self-report measure of state and trait anxiety (Spielberger, 1979);

8. The Assertion Inventory, an 80-item self-report measure of assertive behaviour (Gambrill & Ritchey, 1975);

NB Questionnaires (1 to 8 above) appear in Appendix D, pages 116–145.

Each subject was further assessed by means of an interview during which a general history was taken and in particular it was ascertained whether or not the subject fulfilled the DSM-III criteria for binge-eating, purging and/or rigid dieting behaviours, and self-depreciating cognitions surrounding eating behaviours, body-shape and weight. The Eidetic Parents Test (Appendix D, page 153) was administered on two occasions for the purpose of a different study. The EPT is a 30-item eidetic imagery test with verbally presented scenes involving the parents and the self (Ahsen, 1972). Subjects also completed the self-image test (Appendix D, page 166), a six-item verbally presented imagery test containing scenes of the self as a child and as a thin and big person.

At the beginning of the fifth intervention session, each participant rated the credibility of treatment using three 10-point scales. The scales asked the individual to indicate a) how effective she thought the course was, b) how much she expected to change as a result of it, and c) whether she would recommend it to friends with eating problems. Responses to these questions were anonymous

At the end of the intervention, that is, three weeks after session seven, and again after 30–36 months, participants were asked to complete questionnaires about the content of the course (Appendix D, page 147 and page 149).

4.3 Repeated Measures

Of the measures listed above, the following were used as repeated measures pre-treatment, post-treatment, at the 3-month follow-up, and at 30–36 month follow-up: Bulit, Affectometer 2, Beck Depression Inventory, STAI, Rosenberg's Self-esteem. Subjects also repeated both EPT and Self-image tests at post-treatment assessment.

4.4 Procedure

Potential participants were scheduled for individual screening interviews. At this initial meeting the research was described, informed consent was obtained, and the individual was interviewed regarding her eating history and other relevant details. The first battery of questionnaires had been completed prior to this interview, with the interviewer blind to the results. The interviewer, who also conducted the group sessions, was a graduate clinical psychology student. At this first meeting, the first administration of the EPT (Eidetic Parents test, Appendix D, 153) and self-image test were given (Appendix D, page 166). At a second meeting one week later, a repeated administration of these two tests took place. Participants were told that because of the large response to the advertisement, they might have to wait 13 weeks before beginning group sessions, and that this would depend on the outcome of a ballot. In fact, participants were matched across three groups on the basis of their score on the Bulit questionnaire and the age of onset of bulimia i.e., childhood/adolescence or adulthood. Two subjects who were unable to be matched were placed in a fourth group along with participants who expressed a desire to take part in group sessions but whose scores on the Bulit did not reach a pre-decided cutoff point for inclusion into the study. Results from this fourth group were not included.

Smith and Thelen (1984) suggested two cut-off points for the Bulit, 88 and 102, the former serving to minimise the chance of false negatives, and the latter, false

positives. For the purposes of this study it was decided that the mean of these two scores (95) be used as a cut-off but, in fact, seven of eight subjects in each of the three groups scored over the more stringent cut-off point of 102. One subject was included with a score of 94 in order to complete the grouping.

Of the three groups, one was used as a waiting-list control group, the other two groups were intervention groups. There were 8 subjects in each group. The second of the two intervention conditions was very similar to the first in both philosophy and content but included an additional component consisting of a number of mental imagery (Appendix B, page 88). To all intents and purposes, however, these groups differed little as to treatment conditions. Each group met for 2 hours weekly for 7 weeks.

As well as the initial two individual sessions, all participants were offered the opportunity of an individual session during the seven week period. Participants were also invited to use the University Community Counselling Centre as a further resource if so desired. However, few individuals took advantage of the first offer ($n = 4$; two from each intervention group), and none sought further help from the University Community Counselling Centre. If any member of a group was absent, telephone contact was made as soon as possible, a brief summary of the missed session was given, and the weekly handout was posted to the member. Only one participant was absent more than one session (two sessions). One member from Group 1, and two members from Group 2 were each absent for one session.

Group sessions were held according to the outline found in Appendix B, page ??.

Three weeks after completion of the group sessions, another battery of questionnaires was posted which participants returned during a further individual session (average duration 70 min). The EPT and Self-image test were again administered and participants were encouraged to raise any issues or questions pertinent to their involvement in the study. The interviewer was at this time blind to the outcome measures.

On the initiative of members in each of the two intervention groups, a reunion was planned, and took place after three months, the subjects having completed completed a further battery of questionnaires. Between 30 and 36 months later, 15 of the 16 participants were again contacted and asked to complete a final battery of tests.

5

Results

For ease of reading, the results have been presented in five sections. The first of these is descriptive. The second makes a comparison between pre- and post-intervention measures, and the third examines any differences in outcome between those having a longer or less long duration of symptoms, and those who purge versus those who don't purge. The fourth section examines the two treatment groups at 3-month and 3-year follow-up, while the fifth section contains a post-hoc examination of the measure for bulimia (Bulit).

5.1 Section One: Pre-intervention Results

5.1.1 Subject Profile

The subjects were from varied backgrounds and occupations. They had felt dissatisfaction with their weight from as early as 5 years of age (range = 5–40 years, mean = 15.96 years, sd = 6.95). With the exception of one subject they all reported many attempts at weight loss by dieting, the youngest being eight years of age and the oldest 40 years of age at their first dieting attempt (mean = 17.35, sd = 6.8). Only one third of the subjects ($n = 8$) used laxatives regularly for weight control (mean age of first use = 20.88, sd = 6.2). One half of the subjects ($n = 12$) were vomiting regularly for the purposes of weight control with a mean age of 22.5 years for the first attempts. Awareness that their behaviours constituted what could be called an 'eating problem' (range 11–40 years) developed at a mean age of 21 years (sd = 7.18, range 11–40 years). Many subjects reported a stage of anorexia prior to binge-eating, and at least three subjects may have bordered on being sufficiently underweight to warrant a DSM-III classification of Anorexia Nervosa at the time

of assessment. Four subjects did not menstruate.

It is of interest that over the course of the initial interviews and group sessions, 33% ($n = 8$) volunteered information about prior incest experience. This was not requested and of the remaining 66% ($n = 16$) it is not known how prevalent the incidence of incest was. More than 50% ($n = 14$) reported childhood experiences including severe sexual molestation, rape, incest and/or physical violence. Once again this information was not requested. Nineteen subjects (79%) had joined Weightwatchers on at least one occasion. Many had lost weight initially, one subject as much as 38 kg. Some felt their condition had deteriorated as a result of attendance. Ten subjects (41.7%) had had treatment from psychologists, four (16.7%) had had therapy from psychiatrists, and three had been hospitalised for this disorder. Seventeen subjects (70.8%) had had treatment with drugs on at least one occasion. Acupuncture, hypnosis, prayers with ministers, and psychotherapy were amongst the other methods of treatment subjects had tried. Five had been assisted by hospital dieticians. All but one had tried to lose weight by dieting on numerous occasions. Most of these diets were 'fad' diets. None of these methods were successful with this sample for more than a few weeks. It was noticeable that the majority of the group appeared to be within a normal weight range for their height and age (no measurements were taken). Whilst some were overweight, there were as many underweight. There was no way of detecting their disorder from appearances. Yet, in answer to the question 'What is the current effect of the problem on your life now' (Questionnaire D.1 on page 116), typical responses were: 'I feel inadequate—out of control', 'I feel out of control and insecure, and I feel a lot of guilt', 'I'm out of control. Socially isolated', 'I feel and look revolting', 'an all consuming preoccupation', 'It is with me all the time', 'My life is ruled by the fact that I'm fat' (this subject was of average weight).

5.1.2 Bulimia

Subjects were chosen because of their high scores on the Bulit (test for bulimia), that is a score greater than 94. The mean score for 24 subjects was 115.38 with a standard deviation of 11.23 and a range of 38 (94–132). The only norms to date for the test have been for female university students (norm = 74.3: Smith & Thelen, 1984). There may be a large incidence of bulimia amongst this population, with 3–20% estimated (Moss, Jennings, McFarland, & Carter, 1984; Katzman, Wolchick, & Braver, 1984; Thelen, Mann, Pruitt, & Smith, 1984; Halmi, Falk, & Schwartz, 1981).

5.1.3 Anxiety

For both the state-anxiety and trait-anxiety components of STAI, the mean scores of 40.96 and 48.33 respectively were not significantly more than what would be expected for females of this age range. However, the variances were large (sd = 10.75 and 10.10 respectively).

5.1.4 Esteem

No norms are available for Rosenberg's measure of self-esteem (1979). It is intended that this be used as a repeated measure. However, a mean of 25.4 (sd = 4.59) indicates that the subjects, as a group, had low self-esteem. (NB The higher the score, the lower the self-esteem)

5.1.5 Depression

One would expect a mean for this age group to be about 3.00 with a sd of 4.79 (Beck, et al., 1961). This sample ($n = 24$) had a mean of 8.67 with a sd = 6.66. The degree of depression indicated by the scores is: 0–4 none or minimal, 5–7 mild, 8–15 moderate, 16+ severe. In other words, this sample was, on average, moderately depressed, with a range from 0–23.

5.1.6 Wellbeing

A negative mean for the Affectometer 2 is one which indicates a higher score for negative than positive responses. The mean of this sample ($n = 24$) just fell into the negative sector, (mean = $-.006$, sd = 1.29). The norm for a New Zealand sample of 112 adults was 1.57 with a standard deviation of 1.20, with a scoring range of -4.0 to $+4.0$ (Kammann and Flett, 1983). It can be seen that the mean of the present sample lies more than one standard deviation below this norm. A number of subjects lie more than 2 sd below the mean of the norm, and the majority of subjects have scores below the mean of the norm. That is, the majority of subjects suffer from a very low sense of wellbeing.

5.1.7 DSSI-R

Of the 24 subjects, two fell into class 4 of the hierarchical model (refer to Appendix D.2, page 117), and one subject, into class 3. A further six subjects were categorised as belonging to class 2, and eight subjects to class 1. The classes indicate degrees of personal illness with class 4 representing the most severe diagnoses

(delusions of disintegration, and disintegrated psychosis). Seven of the subjects did not fall into any category (i.e., would not be considered to have a personal psychiatric illness). There was a significant correlation between class and the initial scores on Bulit ($r = .57, p = .003$). The DSSI Class level was also highly correlated with measures of state and trait anxiety (r = .64, p < .005 and $r = .63, p < .005$ respectively), negative wellbeing ($-.48, p < .005$), depression ($r = 48, p < .005$), and esteem ($r = .37, p < .005$).

5.1.8 Self-image Test

Since this test was included for the purposes of another study, only a brief description of it will be given, with no analysis presented. The script is provided in Appendix D.13 on page 166). On the whole the imaged 'thin' selves were reported to be well-groomed, socially adept, confident, not overly interested in food or drink, sexy, and usually socialising or carrying out some career-type activity. The 'big' selves were badly groomed, had poor posture, were not active, were often alone or in compromising circumstances, wore ill-fitting clothes, felt very sorry for themselves, were sexless, and did not have a career. They ate alone and 'wolfed' down food or did not eat. They did not like to be in the company of the 'thin' self and felt guilty about eating and about their shape. The 'thin' selves tended to be very critical of the 'big' selves and did not like them. The most common responses were for the 'thin' selves to criticise or ignore the 'big' selves, and for the latter to feel despairing, guilty and helpless.

5.1.9 Relationship between Measures

In order to find out whether the severity of bulimia was related to wellbeing, anxiety, depression and other variables, Pearson's correlation statistics were applied to a number of the pre-intervention scores of the repeated measures. A summary of these appears in Table 5.1.

Severity of bulimia correlated significantly only with DSSI class and the trait-anxiety component of STAI. There was no correlation between severity of bulimia and degree of depression as measured by the Beck questionnaire. As a measure, the Affectometer correlated highly with all measures except bulimia, state anxiety and assertiveness.

TABLE 5.1: Pearson Correlation Coefficients—pre-intervention test scores (n = 24)

	DSSI Class	State Anxiety	Trait Anxiety	Assert-iveness	Well-being	Depression	Esteem
Bulimia	.566***	.318	.474**	.028	−.329	.157	.257
DSSI (Class)		.636***	.628***	.286	−.483**	.365*	.216
State Anxiety			.659***	.025	−.733****	.469**	.582****
Trait Anxiety				.469*	−.779****	.429*	.682****
Assertiveness					−.285	.322	.448*
Wellbeing						.501***	−.793****
Depression							.337

* $p < .05$
** $p < .01$
*** $p < .005$
**** $p < .001$

5.2 Section Two: Pre- and Post-intervention Comparisons

5.2.1 Groups

Groups 1 and 2 were the intervention groups with the intervention for Group 2 containing mental imagery components. Group 3 was the waiting-list control.

A series of variables were analysed according to a two-factor ANOVA design comprising groups as a between-subject factor and pre-and post-intervention test scores as a within-subject factor.

5.2.2 Measure of Bulimia

A summary of the results for Bulit for pre- and post-intervention time periods is shown in Table 5.2.

A two-factor ANOVA as described above was performed for the Bulit scores pre- and post-intervention. A significant main effect occurred for the group variable, F(2,21) = 5.63, p = .01. Group 3 (waiting-list control) had the highest overall mean, followed by Group 2 and 1 respectively, (means = 113.75, 105.38, and 73.75). There was also a significant main effect for the Bulit test scores, F(1,21) = 20.6, p = .0002. There was an overall drop in the Bulit scores from pre- to post-intervention (means 115.4 vs 97.6).

TABLE 5.2: Mean Ratings for Bulimia pre- and post-intervention, Groups 1- 3

	Pre-intervention Bulit Score			Post-intervention Bulit Score		
Group	Mean	sd	n	Mean	sd	n
1	115.50	11.6	8	73.75	25.55	8
2	114.25	12.6	8	105.38	18.85	8
3	116.38	11.2	8	113.75	9.15	8

Both these main effects were complicated by a significant Group x Bulit test interaction F(2,21) = 9.63, p = .001. Group 3 results on the Bulit test remained relatively stable across time whilst those for Groups 1 and 2 decreased from pre- to post-intervention. This decrease, however, was only significant for Group 1, F(1,21) = 37.9, p<.001 (least significant difference test). The Group 1 mean at post-intervention was significantly lower than the Group 2 mean, and therefore also the Group 3 mean (F(1,23) = 20.0, p<.001.) Groups 2 and 3, however, did not differ significantly from each other. This analysis of variance is presented in Table 5.3.

While the waiting list control (Group 3) did not change significantly over time with respect to the severity of bulimia as measured by Bulit, both the intervention groups improved, with the improvement shown by Group 1 being significant. Since the groups were matched initially on Bulit scores, either there is a marked treatment effect or other factors have caused the differences in results between Group 1 and Group 2.

5.2.3 Depression

Table 5.4 indicates that depression as measured by Beck's Depression Inventory improved over time for all three groups.

These results were analysed according to a two-way mixed ANOVA as described above. No significant main effect for group was found, F(2,21) = 0.65, $p = .5$. However, there was a significant within-subject main effect across time, F(1,21) = 7.03, p<.02. There was no significant group x time interaction effect, F(2,21) = .53. Depression scores decreased for all groups over time, with the waiting-list control group, on average, improving most, from a mean of 9.25 to a mean of 4.5 (moderately to mildly depressed). However, the difference between the groups was not significant, and membership of a particular group did not have

TABLE 5.3: Analysis of Variance: Bulit scores pre- and post-intervention, Groups 1–3

Source	df	SS	MS	F	
Group(G)	2	3604.88	1802.44	5.63	*
Error between	21	6722.13	320.10		
Bulit(B)	1	3780.75	3780.75	20.60	***
B x G	2	3534.13	1767.06	9.63	**
Error within	21	3854.13	183.53		

$* p < .05$
$** p < .005$
$*** p < .0005$

Note: In this analysis there was a large discrepancy among the standard deviations. Although heterogeneity of variance violates an ANOVA requirement, because the cell sizes for the groups were identical, this violation was considered tolerable.

TABLE 5.4: Mean Ratings for Depression pre- and post-intervention, Groups 1 - 3

	Pre-intervention Depression Score			Post-intervention Depression Score		
Group	Mean	sd	n	Mean	sd	n
1	8.38	3.02	8	5.87	5.14	8
2	10.50	6.23	8	8.50	7.76	8
3	9.25	6.99	8	4.50	4.38	8

significant bearing on the amount of improvement shown. A summary of this analysis is presented in Table 5.5.

TABLE 5.5: Analysis of Variance: pre- and post-intervention Depression Scores, Groups 1 - 3

Source	df	SS	MS	F	
Group (G)	2	67.17	33.58	0.65	
Error between	21	1077.50	51.30		
Depression (D)	1	114.08	114.08	7.03	*
D x G	2	17.17	8.58	0.53	
Error within	21	340.75	16.23		

$* p < .05$

5.2.4 Anxiety

The STAI test scores were analysed using the same ANOVA procedure as above for both the state and trait components of Spielberger's Anxiety Questionnaire. Table 5.6 summarises group means for this test. Table 5.7 presents the results of the analysis of variance.

The analysis of variance for state-anxiety scores did not show any significant between-subject, within-subject, or interaction effects. For trait scores, there was no group effect, F(2,21) = 0.08, $p = .069$. However, there was a significant within-subject effect, F(1,21) = 4.37, $p = .049$. There was no interaction effect: F(2,21) = .58, $p = .57$

All three groups improved their trait anxiety scores over time, with Group 1 showing a comparatively greater improvement than the other two groups. The mean scores for both these factors was higher pre-intervention in Group 1, and as can be seen from Table 5.6, subjects' scores were also more tightly clustered about this mean (sd = 5.55).

5.2.5 Wellbeing

Affectometer 2 contains components of negative and positive affect, the total score being the sum of these. For the purposes of this study, the two components were

TABLE 5.6: Mean ratings for State and Trait anxiety pre- and post-intervention, Groups 1 - 3

	Pre-intervention State Score			Post-intervention State Score		
Group	Mean	sd	n	Mean	sd	n
1	40.38	5.55	8	36.00	15.87	8
2	39.88	10.97	8	36.25	10.52	8
3	42.63	14.94	8	39.25	18.74	8
	Pre-intervention Trait Score			Post-intervention Trait Score		
Group	Mean	sd	n	Mean	sd	n
1	51.13	6.73	8	42.25	13.66	8
2	46.75	9.22	8	42.25	13.07	8
3	47.13	13.84	8	44.75	15.85	8

TABLE 5.7: Analyses of Variance: pre- and post-intervention State and Trait scores, Groups 1–3

Source	df	SS	MS	F	
Group(G)	2	84.50	42.25	0.15	
Error Between	21	5882.81	280.13		
State(S)	1	172.52	172.52	2.08	
S x G	2	2.17	1.08	0.01	
Error Within	21	1738.81	82.80		

Group(G)	2	39.54	19.77	0.08	
Error Between	21	4924.38	234.49		
Trait(T)	1	330.75	330.75	4.37	*
T x G	2	87.88	43.94	0.58	
Error Within	21	1589.38	75.68		

* $p > .05$

analysed separately. Table 5.8 presents a summary of means for each group for both components, pre-intervention and post-intervention.

TABLE 5.8: Mean ratings for negative and positive Wellbeing pre- and post-intervention, Groups 1–3

	Pre-intervention Negative Wellbeing			Post-intervention Negative Wellbeing		
Group	Mean	sd	n	Mean	sd	n
1	1.89	0.43	8	1.02	0.67	8
2	1.75	0.85	8	1.40	0.81	8
3	1.85	0.83	8	1.40	0.84	8

	Pre-intervention Positive Wellbeing			Post-intervention Positive Wellbeing		
Group	Mean	sd	n	Mean	sd	n
1	1.92	0.68	8	2.50	0.69	8
2	1.66	0.70	8	2.03	0.82	8
3	1.94	0.82	8	2.28	0.66	8

Note: A decrease in the negative score, and an increase in the positive score indicates improvement.

Separate two-factor mixed ANOVAs were performed for negative and positive wellbeing scores. These are summarised in Table 5.9

From Table 5.9 it can be seen that there were no significant between-group effects for negative or positive wellbeing scores F(2,21) = 0.17, 0.72 respectively. However, significant within-subject effects occurred over time for both negative and positive factors, F(1,21) = 12.66, $p = .002$, and F(1,21) = 9.53, $p = .005$, respectively. All groups showed a decrease in negative wellbeing scores and an increase in positive wellbeing scores (i.e., an improvement in both components).

5.2.6 Esteem

Table 5.10 shows a summary of group means for esteem scores pre-intervention and post-intervention.

A two-factor mixed ANOVA did not show a significant main effect for group,

TABLE 5.9: Analyses of Variance: negative and positive wellbeing scores, pre- and post-intervention, Groups 1–3

Source	df	SS	MS	F	
Group(G)	2	108.04	54.02	0.17	
Error between	21	6666.44	317.45		
Negative(N)	1	1463.02	1463.03	12.66	***
N × G	2	230.04	115.02	1.00	
Error within	21	2427.44	115.59		

Group(G)	2	471.79	235.90	0.72	
Error between	21	6903.13	328.72		
Positive(P)	1	936.33	936.33	9.53	*
P × G	2	61.29	30.65	0.31	
Error within	21	2063.38	98.26		

* $p > .01$
*** $p > .005$

TABLE 5.10: Mean ratings for pre- and post-intervention Esteem scores, Groups 1–3

	Pre-intervention Esteem			Post-intervention Esteem		
Group	Mean	sd	n	Mean	sd	n
1	26.00	5.24	8	20.50	4.38	8
2	24.38	3.93	8	22.88	4.29	8
3	25.88	4.94	8	24.75	4.50	8

Note: Lower scores mean higher self-esteem

F(2,21) = 0.67. However, there was a significant main effect for the repeated measures variable, F(1,21) = 6.86, $p = 0.02$, with an overall decrease in esteem scores (i.e., increase in self-esteem) over the intervention period (means were 25.42 vs 22.7). There was no significant group × esteem test interaction, F(2,21) = 1.83.

5.2.7 Group Differences

To examine possible causes for differences between the two intervention groups, since as previously mentioned the interventions differed little, a post-hoc examination of the two groups prior to intervention was made. Although Student's t-tests revealed no significant differences on any of the initial measures, the ages of members were significantly different (means were 26.4 years and 34.9 years for Groups 1 and 2 respectively, t (14) = 3.337, $p = .005$) Other differences were the duration of dieting behaviour, t(13) = 4.00, $p = 0.002$ and vomiting behaviour, t(6) = 3.27, $p = 0.014$; the duration of dissatisfaction with weight and/or shape, t(13) = 2.91, $p = 0.012$, and duration of the eating disorder as perceived by the subject, t(14) = 3.83, $p = 0.002$. Only the last of these variables was significantly related to outcome, $r = 0.514$, $p = 0.03$. The variable 'duration of eating disorder as perceived by the subject' was calculated from subtraction of self-reported age at first dieting attempts from present age.

The number of subjects reporting sisters with eating problems differed (4, and 7 subjects in Group 1 and 2 respectively). Moreover, 3 of the 8 subjects in Group 2 had been hospitalised for bulimia and related problems (e.g., addiction to dieting drugs), but no subject from Group 1 had been.

A questionnaire assessing subjects' confidence in, and expectation of the course, was given at the beginning of Session 5. This was before the mental imagery components were presented to Group 2. The questionnaire (Appendix D.11 on page 152) asked subjects to rate from 0–10 each of 3 questions: whether they believed the course to be effective, how much they believed they would change as a result of it, and whether they would recommend it to friends with eating problems. A higher rating indicated greater confidence. A summary of the group means for the three questions is given in Table 5.11.

Responses were unnamed and the group leader was blind to outcome until post-intervention testing. Although Group 1 rated each of them more highly, Student's t-tests revealed no significant differences between groups on the three questions, t(14) = 0.8, 1.88, and 1.75, respectively.

TABLE 5.11: Mean ratings for expectancy questionnaire for Groups 1 and 2

	Effectiveness		
Group	Mean	sd	n
1	6.13	2.23	8
2	5.13	2.75	8

	Expected change		
1	6.63	1.92	8
2	4.50	2.56	8

	Recommendation		
1	9.38	0.92	8
2	7.44	3.11	8

5.2.8 Correlations between Improvements

In order to test the null hypothesis that improvements in levels of wellbeing and self-esteem would not be accompanied by an improvement in bulimia, first the improvements for each of the variables shown across all 16 subjects were calculated by subtracting the pre-treatment from the post-treatment scores to provide 'shift scores', which were then correlated with each other (Pearson's product moment correlations). Table 5.12 summarises these correlations.

There was a high correlation between improvement in bulimia and improvement in wellbeing, esteem and trait anxiety. That is, improvements over measures of wellbeing, esteem, and trait anxiety were likely to be accompanied by reductions in the severity of bulimia for this sample. There was also a smaller but significant correlation between improvement in bulimia and improvement in depression.

5.2.9 Summary: Section Two

A summary of the results of repeated measures analysis of variance over the three groups is shown in Table 5.13.

There were no significant main effects for groups over the dependent measures with the exception of the bulimia scores. Here Group 1 showed the most improvement from pre- to post-intervention. On the other hand, for most measures, there were significant within-subject improvements, particularly for bulimia and for the

TABLE 5.12: Correlations between improvements in measures pre- to post-intervention ($n = 16$)

	Bulimia	Wellbeing	Esteem	Trait Anxiety	Depression
Bulimia		−.690****	.663****	.650****	.550*
Wellbeing			−.782****	−.817****	−.624***
Esteem				.660****	.367
Trait Anxiety					.723****

* $p < .05$
*** $p < .005$
**** $p < .001$

Note: Positive and negative wellbeing scores have been summed to give the total wellbeing score. An increase in wellbeing score (positive shift score) indicates greater wellbeing.

TABLE 5.13: Summary of Significance Levels: ANOVAs for Groups 1, 2, and 3 at Pre-intervention and Post-intervention

Dependent Measures	Group	Time (Pre- to post-intervention	G × T
Bulimia	$p = .01$	$p = .0002$	$p = .001$
Wellbeing			
• Negative component	$p = .84$	$p = .001$	$p = .38$
• Positive component	$p = .49$	$p = .005$	$p = .73$
• Total Score	$p = .66$	$p = .003$	$p = .58$
Esteem	$p = .52$	$p = .016$	$p = .18$
Anxiety			
• State	$p = .86$	$p = .16$	$p = .98$
• Trait	$p = .91$	$p = .05$	$p = .56$
Depression	$p = .53$	$p = .02$	$p = .60$

negative component of the wellbeing scale. State anxiety was the only exception to this trend. Only for bulimia was there a significant Group × Time interaction. Although the interventions for Group 1 and 2 were similar, the outcome was markedly different; accordingly, a post-hoc examination was made to find any group differences. A significant difference was found for the duration of the eating disorder as perceived by the subjects. This variable was found to be significantly correlated with improvements in bulimia. Improvements in bulimia tended to be accompanied by improvements in self-esteem, wellbeing and trait anxiety, and to a lesser extent, improvements in levels of depression.

5.3 Section Three: Follow-up Studies

5.3.1 Three-month Follow-up

Both treatment groups continued to improve over all measures after the completion of the intervention. Table 4.14 presents means and standard deviations for test scores at 3-month follow-up.

TABLE 5.14: Summary of 3-month follow-up: test scores for Group 1 and Group 2

	Group 1 ($n = 8$)		Group 2 ($n = 8$)	
Dependent Measures	Mean	sd	Mean	sd
Bulimia	63.13	26.05	98.38	21.04
Wellbeing				
• negative component	−0.85	0.60	−1.01	0.97
• positive component	2.79	0.52	2.39	0.91
• total score	1.91	1.06	1.35	1.85
Esteem	17.38	3.00	21.25	6.76
Anxiety				
• State	34.63	12.18	33.38	11.73
• Trait	39.00	10.52	41.25	14.74
Depression	3.50	3.67	7.75	9.11

The mean improvement across intervention groups was 34.13 points on the Bulit questionnaire, from a pre-intervention score of 114.88 to a 3-month follow-up score of 80.75 (sd = 29.2). This score was below Smith and Thelen's conservative

TABLE 5.15: Summary of significance levels: ANOVAs for Groups 1 and 2 at pre-intervention, post-intervention and 3-month follow-up

	Group	Time	G x T
Bulimia	$p = 0.018$	$p = 0.0001$	$p = 0.002$
Wellbeing	$p = 0.35$	$p = 0.001$	$p = 0.65$
Esteem	$p = 0.39$	$p = 0.05$	$p = 0.53$
Anxiety			
• State	$p = 0.92$	$p = 0.13$	$p = 0.96$
• Trait	$p = 0.88$	$p = 0.02$	$p = 0.53$
Depression	$p = 0.24$	$p = 0.84$	$p = 0.80$

cut-off point of 88. (This study used a cut-off point of 94). Ten subjects (62.5%) in total would no longer be classed as bulimic using the lower of the two cut-off points (refer to Appendix G, page 181 for raw data). Fifteen subjects (93%) showed improvement over their pre-intervention score, with 6 (75%) ceasing self-induced vomiting behaviour. The remaining 2 subjects (25%) had decreased the frequency of both bingeing and vomiting behaviours markedly.

On the Affectometer 2, a mean improvement of 1.69 indicated a positive swing in wellbeing in excess of one standard deviation for the norm (Kammann & Flett, 1983). Trait-anxiety scores decreased on average of 8.8, from a mean of 48.33 to 39.53, which is below what might be expected of a female sample in this age range. The measure for self-esteem has no norms but within-subject changes were significant, ($F(1,15) = 3.32$, $p < .005$; means 25.19 and 19.3 respectively. Depression scores decreased from a mean of 9.44 to 5.63, indicating a reduction from moderate to mild depression (Beck, et al., 1961).

5.3.2 Group Differences at 3-month Follow-up

To ascertain whether the two intervention groups differed at the 3-month follow-up, a series of two-factor mixed ANOVAs were conducted. The two variables were groups (Group 1 vs Group 2) and time (pre-intervention vs post-intervention vs 3-month follow-up). A summary of the probabilities of the F ratios are presented in Table 5.15

For bulimia, there was a significant main effect for group, $F(1,12) = 7.15$, $p = .018$, and a highly significant main effect for the repeated measure $F(2,28) = 24.61$, $p < .0001$. There was also an interaction between the main effects, $F(2,28) = 7.93$,

$p = .0019$. In other words, not only was there a group difference, Group 1 having a considerably lower mean on the Bulit at the 3-month follow-up than Group 2 (means were 63.13 and 98.38 respectively), but also membership in this group was likely to have affected that outcome. However, across both groups over time, the within-subject F-ratio suggests a highly significant improvement in Bulit scores. Interestingly, a significant within-subject improvement was made *after* completion of the intervention (i.e. between post-intervention testing and 3-month follow-up testing), $F(1,14) = 4.6$, $p = .049$, (Refer to Appendix G, page 181 for raw data, for Bulit scores, ANOVAS and treatment of missing data). As at post-intervention, the duration of the perceived presence of an eating disorder was correlated significantly with outcome, $r = 0.53$, $p = 0.026$.

Although there were significant main within-subject effects in wellbeing and trait anxiety (with that of esteem approaching significance), there were no between-group main effects, nor was there any interaction between the main effects. That is, although subjects improved over time for these variables, membership in a particular group did not influence the magnitude of the change. Between the post-intervention period and the 3-month follow-up members of both groups, on average, continued to show improvement at a similar rate.

5.3.3 Correlations between Measures at 3-month Follow-up

In order to show to what extent test scores on the various measures were related, Pearson correlation coefficients were calculated for these over all 16 subjects. Test results at the 3-month follow-up period were highly correlated ($p < .001$) for measures of bulimia, trait anxiety, wellbeing, and surprisingly, depression (refer to Appendix G, page 181). Scores for depression and esteem were also positively correlated ($p < .01$). On the whole, therefore, one would expect any subject remaining severely bulimic to also suffer from anxiety and low self-esteem, and to have a low sense of wellbeing. One would also expect her to be depressed.

A measure of improvement for each variable was found by subtracting the test score at 3-month follow-up from the pre-intervention test score. To test the hypothesis that improvements in wellbeing and esteem would be accompanied by a decrease in the severity of bulimia, these shift scores for each variable were correlated using Pearson's Correlation Coefficient (Table 5.16).

Once again, improvement in wellbeing, anxiety and esteem correlated highly with improvement in bulimia. Improvement in depression, was less highly, but also significantly related to improvement in bulimia. Depression and the other variables were also significantly correlated.

TABLE 5.16: Pearson Correlation Coefficients for improvements in variables between pre-intervention and 3-month follow-up ($n = 16$)

	Bulimia	Wellbeing	Esteem	Trait Anxiety	Depression
Bulimia		−.708****	.794****	.742****	.533*
Wellbeing			−.877****	−.923****	−.7074***
Esteem				.879****	.695***
Anxiety					.687***

* $p < .05$
** $p < .01$
*** $p < .005$
**** $p < .001$

Note: An improvement for wellbeing requires an increase rather than a decrease in the score.

5.3.4 Three-year (30–36 month) Follow-up

The mean score for the Bulit three years after completion of the interventions ($n = 16$) was 73.75 (sd = 21.34). On average the subjects scores on the Bulit had decreased by a further 7 units, resulting in a mean score below a college sample norm (74.3) for this test (Smith & Thelen, 1984). Although Group 1 scored less on average than Group 2 (means were 65.86 versus 81.62), these differences were not significant (see Figure 5.1).

Further improvements were made in wellbeing, self-esteem, state- and trait-anxiety, and depression. These are graphically presented in Figure 5.2. Refer to Appendix G, page 181, for 3-year follow-up data. Only 4 subjects (25%) had a Bulit score greater than Smith and Thelen's (1984) more conservative score of 88 (i.e., 90, 101, 103, 104) at this time. Two of these subjects had particularly low self-esteem (scores = 30 and 30), were depressed (Beck scores = 9, and 21), anxious (state scores = 47, and 48; trait scores = 53, and 60), and were the only subjects to have negative total wellbeing scores. These subjects did not appear to benefit from intervention (but neither did they deteriorate). Duration of the eating disorder as perceived by the subject was *not* significantly related to long-term outcome for bulimia. There were no obvious variables from which it would have been possible

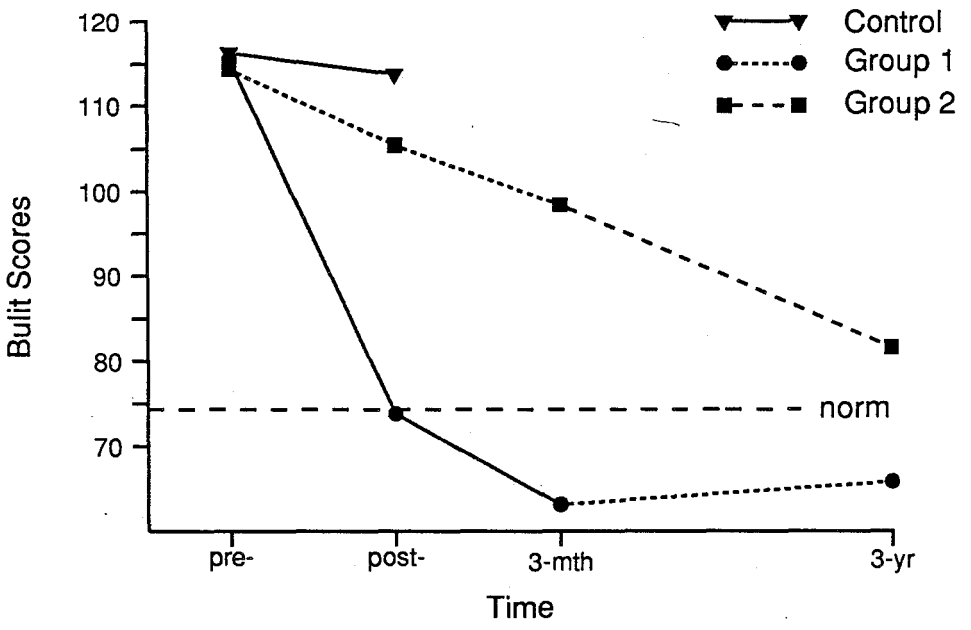

FIGURE 5.1: Bulit scores for Groups 1–3, pre-intervention, post-intervention, 3-month follow-up, 3-year follow-up

to predict other short- or long-term outcomes.

5.3.5 Summary: Section Three

Over the three month period following the post-intervention testing (i.e. nearly four months after completion of the intervention), mean scores for both groups improved across all measures. The two intervention groups only differed on the variable for the severity of bulimia. However, there was no significant difference at 3-year follow-up. All but two subjects (12.5%) showed considerable improvement across all measures.

Only one subject vomited regularly (with a further subject vomiting occasionally), and this subject had reduced her frequency from four-hour daily

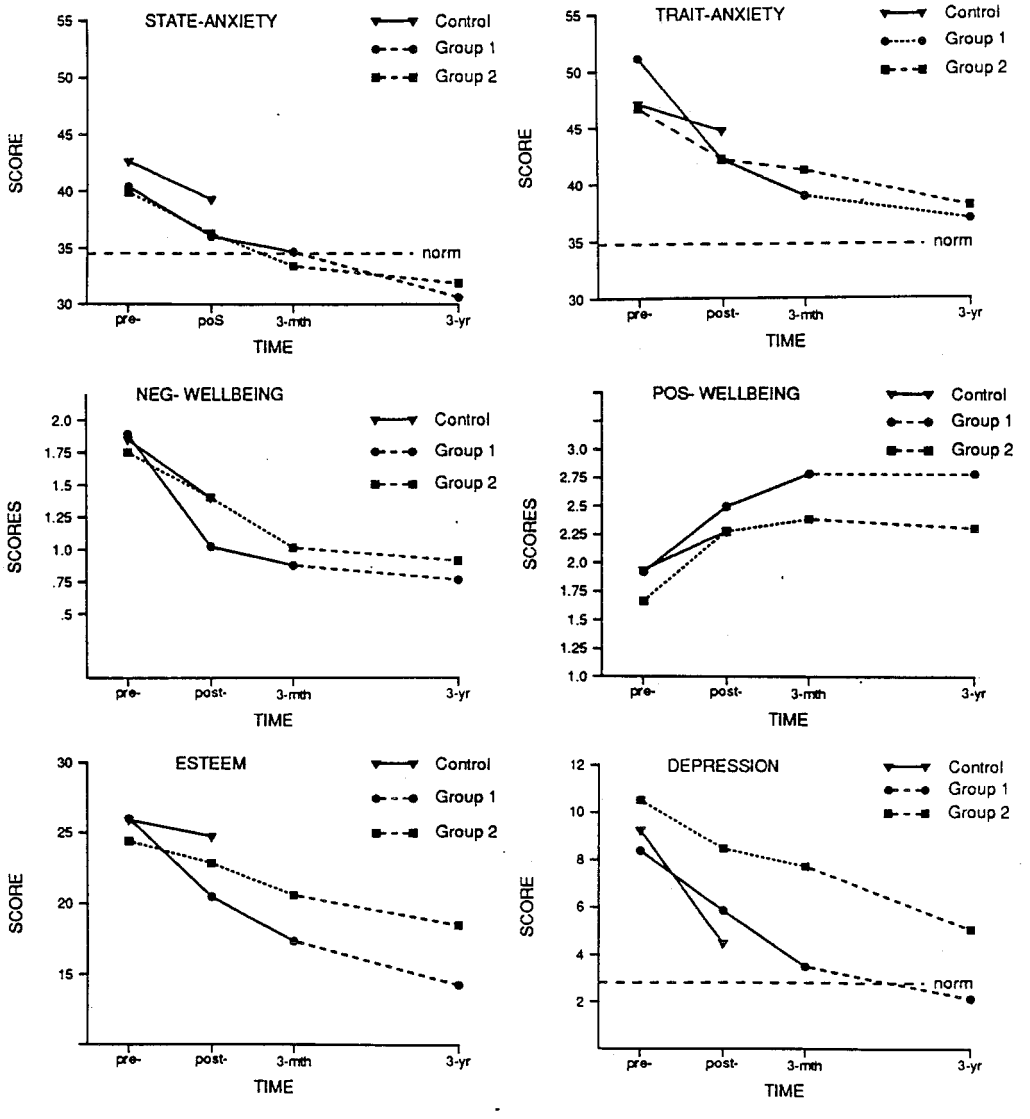

FIGURE 5.2: Changes in measures of general psychopathology over 3 years for Groups 1–3

binge/vomiting episodes to several (2–3) discrete episodes per week.

5.4 Section Four: Predictors of Outcome

This section of the results examines factors which might have affected treatment outcome.

5.4.1 Duration

In order to test the null hypothesis that the duration of the disorder does not have any bearing on outcome, several measures of 'duration' were computed. These were the duration of dissatisfaction with body weight and shape ($n = 16$), duration of dieting behaviour ($n = 15$), and duration of vomiting behaviour ($n = 8$) (refer to Section 5.2.7 for method of calculation). No significant relationships were found between these measures and the measure of bulimia, either post-treatment or at 3-month follow-up. However, as reported earlier, the perceived duration of an eating disorder correlated significantly with outcome at post-intervention and 3-month follow-up (but not at 3-year follow-up; refer to section 5.2.7 for statistics). The null hypothesis was therefore accepted only for the duration of bulimic *behaviours*.

5.4.2 Binge/purge versus Binge/diet Subtypes of Bulimia

An ANOVA was performed using vomiting ($n = 8$), and non-vomiting ($n = 8$) as a grouping factor and improvement in Bulit scores as a within factor. There was no main effect, either post-intervention, or at short-term follow-up. Although the vomiting group had significantly high behaviour scores initially (see results Section 5.5), this was not the case by the 3-month follow-up. Only two of the eight (25%) in this group were still vomiting by the 3-month follow-up. No subject used laxatives or diuretics at this time. The null hypothesis that outcome would not differ for these subtypes of bulimia was supported.

5.4.3 Other Possible Predictors of Outcome

As well as duration, and subtype of bulimia, other factors might be thought to predict outcome, such as esteem (Fairburn, 1988b; Garner et al., 1987). However there was no significant correlation between age, or pre-intervention measures of anxiety, self-esteem or depression and severity of bulimia at 3-month follow-up. Neither was the initial severity of bulimia an indicator of outcome ($r = -.072$, $p = .39$). However, some measures at 3-month follow-up did have some predictive

power for severity of bulimia after three years. These were self-esteem ($r = .623$, $p = .005$), anxiety ($r = .526$, $p = .019$), wellbeing ($r = .618$, $p = .008$), and bulimia itself ($r = .717$, $p = .001$). Levels of depression at 3-month follow-up were positively but not significantly related to severity of bulimia after three years ($r = .21, p = .22$).

5.5 Section Five: Analysis of the Bulit

5.5.1 Behavioural and Cognitive Components

Since the aim of intervention was to alter cognitions and behaviour, the Bulit was broken down in order to examine more closely changes taking place during and after intervention.

The Bulit was divided into three components: those questions relating to specific behaviours, those questions relating to cognitions and those questions relating to labelling, preferences, opinions, past weight gains and losses, and menstruation. Categorising the questions presented some difficulties. Some questions clearly related to behaviours, such as 'How often do you intentionally vomit after eating?' (question 15). Thirteen questions were placed into this category (item numbers 1, 3, 7, 8, 9, 12, 15, 17, 19, 21, 30, 31, & 34). However, the wording of many of the questions indicates a confusion between cognitive and affective elements. For example, 'I don't like myself after I eat too much' (question 14), 'I am satisfied with my eating' (question 2), and 'Do you feel you have control over the amount of food you consume?' (question 6), and 'I am afraid to eat anything for fear that I won't be able to stop' (question 13). This category more accurately includes non-behavioural rather than strictly cognitive elements. However, for the purpose of clarity, it has been labelled 'cognitive'. Included are item numbers 2, 6, 10, 13, 14, 16, 20, 22, 23, 26, 28, & 29 (n = 12). The third category, not used in analysis, includes item numbers 4, 5, 11, 18, 24, 25, 27, 32, 33, 35, & 36 ($n = 11$).

The behavioural and cognitive components were compared across time for all 16 subjects taking part in the intervention (see Table 5.17). At pre-intervention, there was a significant difference in the behavioural and cognitive scores, t(14) = 5.28, $p < .001$, means were 36.00 and 46.00 respectively, even though the former score included one more question.

Subjects on average showed significant improvement by the time of the 3-month follow-up, both on the behavioural score, (t(14) = 3.97, $p = .0014$), and the cognitive score (t(14) = 4.68, $p < .001$). A comparison of the differences in improvement reached significance (t(14) = 2.34, $p < .05$) with a greater improvement shown in 'cognitions' (means were 10.88 and 15.88 respectively). However, the cognitive

TABLE 5.17: Mean Scores for Behavioural and Cognitive Components of the Bulit ($n = 16$)

	Pre-intervention		3-month Follow-up	
	Mean	sd	Mean	sd
Behaviour	36.00	5.87	25.13	10.01
Cognition	46.00	5.90	30.13	13.12
Bulit	114.88	11.72	80.75	29.23

score remained significantly higher than the behavioural score t(14) = 2.56, $p < .05$ (means were 25.13 and 30.13).

5.5.2 Group Differences

Analysis of variance showed no significant differences between the two intervention groups at pre-intervention for either behavioural or cognitive scores. However, during the course of the intervention, Group 1 experienced a significantly greater change in both cognitions and behaviour than Group 2, t(14) = 2.44, p = .028, and t(14) = 3.08, $p = .008$ respectively. However, although this difference was maintained for cognitions at the 3-month follow-up, t(14) = 2.67, $p = 0.18$, means = 23.5 and 8.25 respectively, this was not the case for behaviour t(14) = 1.52, $p = .15$, means = 14.88 and 6.88 respectively.

At the three-year follow-up, no significant group differences were found.

5.5.3 Summary: Section Five

For both groups significant improvements were made over time in scores of both the behavioural and cognitive components of the Bulit. Although there were between-group differences in these improvements at post-intervention, these were non-significant after 3 years.

6

Discussion

This chapter includes a brief discussion related to each of the five sections in the previous chapter followed by a general discussion of the issues raised by this study.

6.1 The Sample

The sample involved in this study perhaps differed from some samples of those suffering from bulimia in that the subjects answered a newspaper advertisement. However, their lack of assertiveness, low self-esteem, and higher than normal levels of anxiety and depression were typical of samples from other studies. Many of the subjects had attempted (some successfully) to keep the extent of their psychopathology secret, even from family members and spouses. The range of ages, and particularly their ages of onset of bulimic behaviour in the sample belied the assumption that bulimia is a 'young persons' disorder. This assumption itself may have been based on biased sampling, particularly in the light of the fact that most studies have involved university students.

On average, these subjects had felt dissatisfaction with their body shape/weight for over sixteen years, and in some cases more than twenty-five years. On the whole, their lifestyles reflected their psychopathology with the majority being unmarried, and few having satisfactory relationships with spouse, boyfriend, or with others. Many were socially isolated but presented as friendly, sensitive individuals - perhaps oversensitive to social cues. On the whole, the results indicated more than anything else the extreme individual variation within the group on all measures except the presence of the bulimic behaviours and related cognitions.

6.2 Pre- and Post-intervention

Given that the interventions for Group 1 and Group 2 differed minimally, it was surprising to find that on several variables, notably bulimia, there were significant group effects found. It would seem unlikely that the inclusion of the mental imagery tasks for the Group 2 intervention would have played a major part. In actual fact, two of the subjects who had improved least post-intervention, chose not to participate in the tasks or did not complete them (refer to Appendix B, page 72). The group sessions were conducted in such a manner as to encourage participation of subjects, and it is possible that the different outcome was to some extent a function of the group dynamics.

In any case, the differing results for the two groups serve to emphasise the heterogeneity of those suffering from bulimia, and that the results of studies based on small samples need to be viewed with caution.

Test results for the waiting-list control group (Group 3) support current thinking (Fairburn, 1988a) that experimental design no longer needs a control group because with no intervention the severity of bulimia remains relatively stable over time. There were, however, several measures on which the waiting-list control group showed greater than expected improvement. These were depression, trait-anxiety, and wellbeing.

Improvements shown over the waiting period for these three variables can't easily be explained away by regression to the mean. Perhaps the waiting-list controls were positively affected by the course introduction and testing procedures, which may have instilled hope for the alleviation of their distress as a result of their expectation for future participation in the intervention. Why did this not in turn, bring about an improvement in their bulimic behaviours? One explanation might be that an improvement in self-esteem is essential (the waiting-list control did not show mean improvement on this measure). Supporting this explanation are the high correlations between improvement in bulimia and increases in self esteem. Although others (e.g., Fairburn, 1988a) have found self-esteem to be predictive of outcome, this was not found to be the case in this study. However, it is likely that an improvement in bulimia may be alleviated by different mechanisms in different cases. In the majority of studies improvement in bulimia would seem to increase self-esteem. The author suggests that in the present study the increase in self-esteem or decrease in negative evaluation may have influenced the bulimic behaviour and cognitions.

The comparatively small decrease in depression for the two treatment groups at post-intervention is interesting given the hypothesis that, although those suffering from bulimia tend to be depressed, the bulimic behaviours themselves tend to moderate this depression (refer to Chapter 3). In the present experiment the group

which showed little or no change in bulimic behaviours (the control group) showed markedly decreased depression scores, whereas the group which showed significantly greater improvement in bulimic behaviours (Group 1), showed considerably less improvement on mean ratings for depression (means 8.38 v 5.8). One would expect that those showing an improvement in severity of bulimia would also be less depressed *unless* a reduction in bulimic behaviours uncovers a degree of depression formerly hidden by, or tempered by the presence of bulimia. This hypothesis would also provide an explanation for the fact that although the subjects as a group were depressed, within that group, the correlation between the severity of depression and the severity of the bulimia was low, $r = .26$, $p = .11$. It should be noted, however, that these two variables were correlated significantly by 3-month follow-up, $r = .70$, $p = .001$.

Improvements shown by subjects over a number of measures, notably that for bulimia, would appear to be too great to be accounted for by drift over time, regression to the mean, or experimenter effect. One must conclude that the intervention was in some way responsible. It is suggested that the improvement in the severity of bulimia was in someway mediated by improvements on other variables, because bulimic behaviours were not addressed specifically. Improvements in bulimia were highly correlated with improvements shown by measures of self-esteem, wellbeing, trait-anxiety, and, to a lesser extent, depression. The null hypothesis that these were not related was therefore rejected.

6.3 Predictors of Outcome

Duration of the disorder was not significantly related to outcome when duration was assessed in terms of the actual *behaviours* of vomiting or dieting. Duration of bingeing was not assessed because of the subjective nature of the term. However, when the duration was assessed in cognitive terms, that is, how long the subjects had *perceived* themselves as having an eating problem, a significant correlation was found. It may be that the perception of the eating disorder as being long standing led to a reduction in self-efficacy which mediated treatment efficacy. The correlation between perceived duration of disorder but not actual duration of disorder appears to support a cognitive model of bulimia. Those who have perceived themselves as having suffered from an eating disorder for a longer time may be more resistant to change. It is suggested that changing ones belief may be less easily accomplished than changing ones behaviours, especially when those beliefs have been held for a long time. In any case the results of the present study do not support the view that prognosis is poorer amongst those who have exhibited bulimic behaviours for a

longer time. The null hypothesis that longer duration may not be related to outcome is accepted for behaviourally assessed duration but rejected for cognitively assessed duration.

6.4 Follow-up Studies

On average, further improvements over all variables were made by members of each group both post-intervention and at 3-month follow-up. There was a significant group effect for bulimia at 3-month follow-up but not at 3-year follow-up. It would appear that subjects in Group 2 improved more slowly than subjects in Group 1, but nevertheless did improve significantly. By the 3-year follow-up study only 4 subjects across both groups exceeded Smith and Thelen's (1984) more conservative cut-off point classification of bulimia. Of those who vomited regularly at pre-intervention ($n = 8$), 6 were abstinent at 3-month follow-up and remained so at 3-year follow-up. Both the remaining subjects had decreased the frequency of self-induced vomiting by more than 75% by 3-month follow-up and this was maintained at the 3-year follow-up.

6.5 Conclusion: A New Perspective on Bulimia Intervention?

Behavioural treatments for bulimia attempt to modify the behaviours specific to the disorder. Cognitive behavioural treatments also attempt to modify the cognitions associated with these behaviours. A post-hoc analysis of the Bulit scores revealed that in the present study both the behaviours and cognitions were significantly modified. The current intervention differs radically from those which focus on these specific psychopathology and behavioural manifestations of the bulimia. The current intervention encouraged the subjects to regard their bulimic behaviours as functional, thus alleviating feelings of guilt and loss of control typically found in sufferers of this disorder. It further attempted to de-emphasise the importance of bingeing and purging behaviours in the subjects' lives by focusing instead on the development of interpersonal skills, cognitive restructuring of distorted beliefs, problem-solving skills, and increasing self-efficacy. It is hypothesised that at least part of the treatment efficacy was due to newly acquired and more adaptive skills providing the reinforcers which previously maintained the bulimic behaviours.

The intervention was relatively brief compared with the majority of previous studies. The attrition rate was low (0%) in an area where 20–30% attrition is usual

and up to 60% even with stringent selection criteria is not unusual. The post-intervention outcome was positive with a trend for continued improvement until the 3-year follow-up. In an area where treatment efficacy has remained equivocal, these results suggest that credibility must be given to the efficacy of a functional model as a basis for intervention for bulimia. The results of this study suggest that a broader perspective might be taken on the disorder, and that the present research bias in favour of cognitive behavioural treatments which focus directly on bulimia related behaviours and cognitions may not be warranted. An area of possible interest for further research is to compare group and individual administration of interventions of the type used in this study. A further area of study would be to compare outcomes of shorter and longer interventions. The continuing gains revealed by the long-term assessment in the present study clearly indicate the desirability of long-term follow-ups for a realistic evaluation of the efficacy of any intervention for bulimia.

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Personal Communication

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Appendix A

Definitions and Models

A.1 DSM-III Diagnostic Criteria for Bulimia

A Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours).

B At least three of the following:

(a) consumption of high-caloric, easily ingested food during a binge

(b) inconspicuous eating during a binge

(c) termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting.

(d) repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics

(e) frequent weight fluctuations greater than ten pounds due to alternating binges and fasts.

C Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.

D Depressed mood and self-depreciating thoughts following eating binges.

E The bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.

A.2 DSM-III-R diagnostic criteria for Bulimia Nervosa

A Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).

B A feeling of lack of control over eating behaviour during the eating behaviour during the eating binges.

C The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.

D A minimum average of two binge eating episodes a week for at least three months.

E Persistent overconcern with body shape and weight.

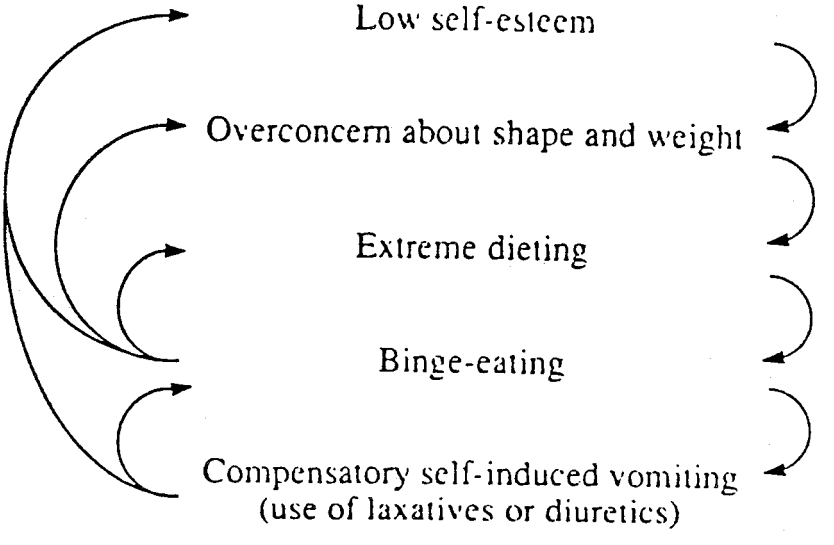


FIGURE A.1: A Cognitive Model of Bulimia (Fairburn 1988a)

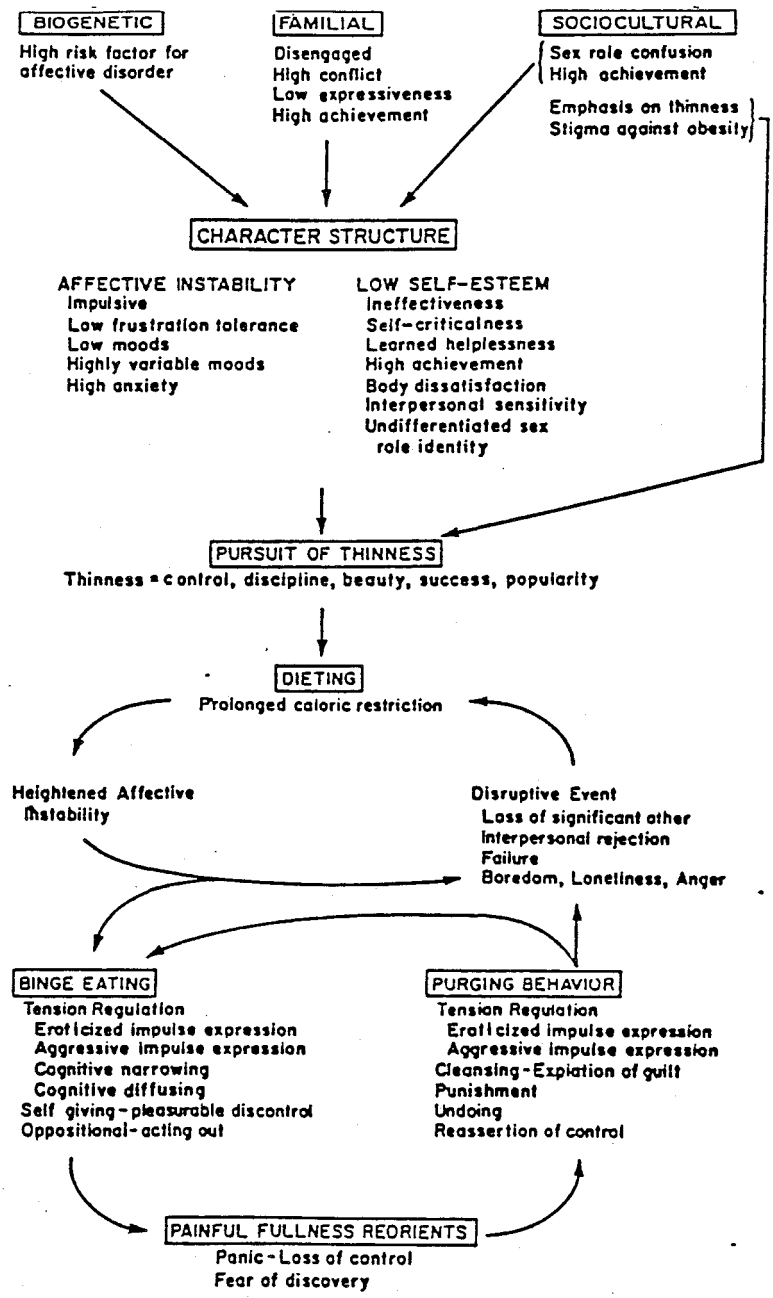


Figure 1. The etiology of bulimia based on the patient's biogenetic, familial, and sociocultural background.

FIGURE A.2: The etiology of bulimia based on the patient's biogenic, familial, and sociocultural background (Johnson, Lewis, & Hagman, 1984, p. 257)

Appendix B

Intervention

B.1 Group Sessions

The following is a brief outline of the content of each of seven weekly group sessions. It is not meant to be a treatment manual. Participation of members was encouraged.

B.1.1 Week One

- Members and therapist formed a circle
- Members were introduced to each other on arrival.
- Participants were praised for their courage in attending, especially because of the shame and guilt felt by those suffering from eating problems, and the desire for secrecy. They were also thanked for being prepared to take part in the research project.
- Confidentiality of what took place during sessions was stressed.
- The importance of commitment to the group was pointed out, not only for the sake of the research, but more importantly, for the sake of other group members. Participants were asked to consider very carefully whether they were ready to make this commitment and, if necessary, withdraw before the next session.
- Group business, for example, starting and finishing times, location of toilets and so on, was dealt with. All discussion was to stop when the group disbanded for the evening.

- Members were asked to bring a notebook and pen to each session and to use them freely to take notes.
- The subject of emotions during group sessions was broached. It was pointed out that some of the content of sessions might be painful to some members, and crying was acceptable. Other group members were encouraged to allow an upset person to be upset, rather than to immediately try to cheer them up.
- The philosophy underlying the sessions was briefly reviewed again (refer to handouts).
- Laughter was frequent but never at the expense of members.

Name Game; Participants took part in a circular name game.

Pairs; Subjects divided into pairs. For five minutes each partner was to listen to the other with no comments whilst she talked about herself. If possible, she was to talk about her eating problems[1], but if not, general subjects would be acceptable. On completion of this task, each pair combined with another pair. Each person took turns at *pretending* to be their partner and telling about herself. Participants had the right to ask her partner to be silent during this game. [Not only did this encourage self-disclosure and development of listening skills, but it was also thought provoking.]

Large Group: Starting with the leader, each individual spoke briefly about her aims and aspirations for group participation. [Many participants expressed a desire to lose weight and regain control of their behaviour, in spite of the orientation of the course having been explained to them.]

Education Component: The purpose of this component was to provoke examination of the individual's belief system regarding herself, eating, diets, and so on. A comparison was drawn between those behaviours which were considered problematic and similar behaviours practised by members of many religious sects involving starvation, purging, and bingeing.

A historical overview of fashion and politics as relevant to perceived desirability of various female shapes and sizes was given. In the light of this a close look at some of the social pressures on women of the 1960's-1980's to be slim were examined in a broader context. Individuals were encouraged to

[1] At no time was the label bulimic, or bulimia used.

participate in this discussion. [Pressures included those from the media, advertising, models who were superslim in magazines and movies, the prevalence of diet books, the unavailability of attractive clothes in larger sizes, and comments from family members, friends, males, and so on.]

A suggestion that slimness might be comparable with fashion dictating that women, for example, wear high heeled shoes, have their feet bound, wear corsets so tight that proper breathing becomes difficult, wear dresses, especially full and long ones, wear very tight skirts, or have elaborate hair styles, each of which make it difficult for women to move freely and purposefully compared with male garb. Endeavours to be slim, with perhaps the resultant lack of energy, and the lessening of physical presence, may render females powerless.

The latest research in the physiology of food restriction that is, dieting, was presented. The research indicates that changes in metabolism may take place with a resulting *increase* in weight when eating returns to normal, that a restriction in food intake causes physiological response of bingeing, that diets are *unsuccessful* for 98% of attempts (Polivy & Herman, 1985). [Participants were amazed at this information, and had seen attempts at dieting culminating in bingeing or weight-gain to be personal failures rather than an inherent failure of 'crash' diets to be an effective way to lose weight long-term. Note: Whilst information about the harmful effects of bingeing, restrictive dieting, vomiting and laxative abuse, wasn't withheld, it was pointed out that most participants already knew these negative outcomes of the behaviour, and that that had *not* resulted in a behaviour change on their part. [Several participants had suggested that a discussion on these harmful effects might provoke them, via guilt and shame, to change their ways.]

It was suggested that there may be *good* reasons for an individual to carry out bingeing, purging, and dieting behaviours, and that a discovery of what these reasons might be would give the individual the option of learning alternative ways of behaving instead, if she chose to. [This was a particularly foreign idea to participants who saw this bingeing behaviour as a sign that they were a failure as human beings. Consequently they sought a way to control these impulses which, ironically, they also viewed as outside their control.]

Self-talk A discussion on how much one is affected by what people say led to an examination of how one is affected by self-talk. Participants were encouraged to self-disclose about their own self-talk and the effect it might have on

them. No suggestions were made at this point about how self-talk could be changed but members were encouraged to observe their own self-talk during the week, and record some examples in their notebooks.

Note All homework set was to be done at the discretion of the individual, that is, she could choose to do it or not. Whilst social reinforcement by way of increased attention was given to those who completed assignments, no reprimands were given to those who didn't. It was stressed, however, that how much benefit an individual received from the course partly depended on how much effort she was prepared to make with homework assignments. *No* assignment involved either the eating or not eating of particular foods, or any other form of direct control of eating/purging behaviours.

Assignment As well as observing self-talk during the week, participants were asked to say 'I choose to ..... because .....' whenever they found themselves eating, bingeing, dieting, or taking laxatives. If an answer came to mind they were asked to record it, otherwise they were to say the words and record the thought following them. It was explained that at this point it did not matter if reasons did not come to mind.

Note: The main reason for this exercise in fact wasn't to discover the reason for the behaviour but rather to put the responsibility for the behaviour onto the individual rather than have her see it as something outside her control. [Those who voiced difficulty with this exercise were later found to be the same ones who were not able to complete the mental anxiety tasks (Group 2).]

Summary A brief summary of the evening's session was given. Participants were again asked to telephone the leader if they wished to withdraw or if for any reason they couldn't attend a session. An indication was given of what was to be discussed the following week. This included looking at some reasons why people 'choose to ...', and some of the advantages to be found in being overweight, bingeing, dieting and so on.

B.1.2 Week Two

A discussion about the assignment took place. From week three on, this initial weekly discussion was formalised with each member having 3 minutes to tell the group about any relevant details of her week. [During this discussion a number of participants, (5), the majority from Group 2 (4) stated that they

had found the assignment difficult or impossible. However, most had also come to the conclusion that this must be because they did not want to take responsibility for their behaviour. The leader suggested that they say instead 'I choose *not* to say 'I choose' because ...', on each occasion. All but 2 (both from Group 2) were able to progress from this step after several days.] In both groups, members' self-disclosures provoked a good deal of discussion. Many participants had found a number of reasons for their behaviour springing to mind spontaneously. Amongst these were boredom, loneliness, feeling overwhelmed, being criticised or put down, anger, guilt, self-hate, feeling fat already, and feeling helpless. The leader affirmed that all of these were excellent reasons for the behaviour, that there was an abundance of food in our society, and that bingeing was a relatively harmless way of coping with these feelings. However, during the course of the group sessions a number of skills providing alternative ways of dealing with these feelings would be offered. After that point each individual would have a *choice* of ways of behaving in a particular situation rather than just the one, albeit successful, way she had already, that is bingeing and consequent behaviours. There may be times in the future when she chooses to use her eating behaviour to assist her to cope with what is going on in her life. [The rationale behind this reframing is to free the individual from the guilt and shame which would be attached to the behaviour if it were to be seen as a relapse, and she was encouraged merely to see her behaviour as an indication that something is going on which she might choose to examine more closely, such as, stress, or particular feelings.]

Choice A reiteration of one of the underlying philosophies of the intervention was made, at some level we *choose* our behaviour, and furthermore that our choice is the very best we can make for ourselves at that time. The course offers new ways of behaving that expand the repertoire from which these choices are made. The individual, having learnt new skills, may find that she is choosing bingeing, vomiting behaviours less and less often.

Small Groups The group divided into smaller groups to discuss advantages and disadvantages of being both bigger (i.e., 'fatter') and smaller (i.e., 'thinner'). The rationale behind this task was two-fold. Firstly, individuals examined exactly *why* they thought being thinner was better or why they thought they would be happier, and whether these beliefs were realistic. Secondly, there might have been hidden secondary gains in being heavier of which the individual had been unaware. Each of the small groups reported a number of advantages and disadvantages back to the whole group. [It was surprising to

the members that they could think of any reasons *why* it would be beneficial to be heavier, or even the weight that they were presently.]. Participants were asked, also, to recall their 'thin' and 'big' self-images (refer to Appendix, page 88). The members of the group made suggestions about other possible ways of having the advantages (or not having the disadvantages) without their dependence on weight or size. [For example, one advantage of being overweight was avoiding wolf-whistles. Alternative ways of dealing with wolf-whistles were generated. A more important example was being overweight to avoid relationships and/or sex (both groups). Alternatives generated by group members included making a conscious decision not to have relationships and/or sex, that is, learning to say no verbally regardless of size or weight.]

Conflict One of the characteristics of eating problems is ambivalence or conflict. For example, wanting to binge versus wanting to diet, wanting to change versus being afraid to change. Some of these were discussed, particularly the conflict or 'no-win' situation, likely to arise when using the word 'should' - refer to handout 1, part 1, Appendix C, page 94.

Homework Homework included continuing to say 'I choose ....', monitoring of negative self-talk, and observations of reactions to use of the word 'should' in self-talk.

B.1.3 Week Three

Sharing circle Members had three minutes each to talk about their week. Those who told of discoveries or successes related to group sessions or homework were reinforced by attention and praise. Those reporting negatively were not. However, if the individual was seeking assistance for a problem arising through the week, this was noted by the leader and used as a discussion point after the completion of the sharing circle. Ways of dealing with the problem were generated by members of the group with the guidance of the leader and along the lines of the group philosophy, that we *always* have and make choices, and whatever choice is made is the best possible one given our present skills and knowledge. Problem-solving techniques were modelled on these occasions but not formally introduced at this stage. [Members contributions either directly reinforced what had been discussed over the first two sessions, or were used by the leader to do so.]

Homework Matters arising from homework were discussed.

Beliefs A discussion took place about how our belief system has been formed through our experiences, and how we continue to affirm our belief system. [Members offered some negative beliefs about themselves and how they might have arisen. However, although these self-disclosures were welcomed, they were not actively sought.] The power of self-talk to affirm beliefs was discussed. It was suggested that it is possible to change self-talk and thereby to change beliefs. The notion of affirmations were introduced. It was stressed that skills involving thoughts, like other skills, go through a number of stages before becoming a comfortable part of our repertoire. An analogy was used when learning skills throughout the course, with learning to drive a car. Four basic stages of skill learning are:

1. incompetent and not knowing it
2. incompetent and knowing it
3. competent and 'self-conscious'
4. competent and natural

We could be at any stage of these stages as related to a particular skill. For example, a person who does not believe she has the right to say 'no', would be at stage 1. If she believes she has the right but doesn't know how to go about saying 'no', she is at stage 2. If she has learned some techniques for saying 'no' but feels uncomfortable when she uses them, she is at stage 3. When she becomes adept at these skills and they become 'natural' for her, then she has reached stage 4. Using affirmations follows the same steps. Not knowing the power of self-talk and how to change it in order to believe what you want, is stage 1. Knowing that it is possible but not knowing how, or using the knowledge, is stage 2. Using the affirmations but not yet believing them is stage 3, and by stage 4, the new beliefs have been incorporated into the belief system.

Exercise in pairs Beliefs, skill learning, and affirmations were incorporated into an exercise where one partner complimented the other (members were encouraged to compliment on non-appearance-related things, if possible). The person who had been complimented had to respond in a positive way, thus reinforcing her complimenter, and, at the same time, affirming that the compliment was justified. It was stressed that it didn't matter if the compliment was actually *believed* yet.

Changing beliefs Three skills were introduced:

1. Reinterpreting situations or, thinking of positive alternatives. This applies to one's own thoughts and actions and those of others. Examples were provided for members to reinterpret, for instance, a man has been shot in the foot, what could be positive about this? One answer might be that 'the man is a soldier who is removed from the front line because of his injury'. 'I'm really lazy' could become 'I'm really pleased I am the sort of person who is able to relax.' It was once again stressed that it was not necessary to *believe* the new interpretation to play the 'Reinterpret Game.'
2. The 'as if' game involves acting 'as if' something were already true, such as, acting 'as if' you can accept compliments comfortably, or 'as if' you are a cheerful/bright/friendly/brave person.
3. Using affirmations. (refer to handout - part II, Appendix C, page 94).

Affirmation Game Each person, including leader, thought of some belief she would like to hold of herself, or alternatively, though of a negative thought about herself, and rephrased it into its opposite. Each person in turn disclosed this thought to the group. Each person then stated the thought in the form 'I am ...'. Next time around the circle, individuals were to say the statement 'as if' they believed it. This was repeated several times. When other members did not 'believe' what had been said because it had not been said firmly enough, they requested that it be repeated. [After this game, some individuals remarked that they 'could almost believe' what they had said. Several even said that perhaps, on some occasions, it was true. This not only caused hilarity but was an opportunity for the leader to reinforce the notion that affirmations are very powerful.]

Affirmations Time was set aside for practise in the use of affirmations as per handout, part II (Appendix C). An important point was made regarding change. This was that it is also important to accept oneself as one is, right now. Change may be desirable, and is certainly possible, but it is *not* essential in order to consider oneself a worthwhile person.

NB: Many persons who suffer from eating problems believe that IF they lost weight, or IF they stopped bingeing they would like themselves, be good to themselves and so on. That is, self-acceptance is conditional on weight, shape and/or self-control.

Homework Participants were to read and complete assignments in handout part II (Appendix C). They were encouraged to continue to monitor self-talk with

attempts to reinterpret negative self-statements, taking a note of those with which they had difficulty.

B.1.4 Week Four

Sharing circle This task took the format as in week three. [The sharing circle and the discussion/problem-solving arising from this and homework assignments took in excess of one hour.]

Review A review was given on using 'I choose' instead of 'I should ...', playing the 'as if' and 'reinterpret' game, the use of affirmations, and the forming and changing of beliefs. As much as possible, individuals provided this information. NB: Socratic method of assisting group members to find the answers or make discoveries themselves, was used extensively and at every opportunity throughout all sessions. The leader attempted to resist being the 'expert'. In this way the self-efficacy of members was enhanced, and all members were encouraged to believe they had also made a worthwhile contribution towards others in the group. Contributions of a worthwhile nature such as, self-disclosure reinforcing the content of the discussion, was strongly reinforced.

Assertiveness The notions of assertiveness were introduced. (Appendix C). Extensive discussion took place on what our individual rights are, first in small groups, then in the large group. [The list generated included: the right to have needs, wants and desires, the right to have opinions, the right to say no, and the right to ask or request.] Members were asked which skills they would find useful to learn (e.g., how to say 'no'). Different styles of getting one's own way - or not, were discussed, including, passive, aggressive, assertive styles, with possible advantages and disadvantages of each style discussed. Some role-playing using printed material illustrating each style was included.

Homework Individuals by now had differing homework tasks depending on matters arising for them from discussion, as well as group homework. Handout part III (Appendix C) was distributed to be completed. At the end of the session it was again stressed that doing homework (or not) was the choice of the individual. [Fears of change, or changing too fast, were raised in both groups. Leader offered the belief that people change in their own time, and at their own pace. Using affirmations to deal with these fears of changing, plus methods of self-exploration in order to find out the basis of the fears, were suggested. Reinforcement was given for allowing changes to occur quickly.]

B.1.5 Week Five

Sharing circle This took place as in previous sessions with discussion at completion of the circle.

Homework Handout part III was discussed (refer to Appendix C). The major ideas presented were:

1. Separating feelings from eating behaviours using affirmations e.g., 'It's OK for me, ..., to feel angry (bored, lonely, or whatever), regardless of whether I choose to eat or not.' 'It's OK for me, ... , to have and feel needs, regardless of my eating patterns, or my weight.'
2. Food-related behaviours will continue to carry out their worthwhile functions of helping one cope with underlying feelings or problems until such time as, a) these problems are recognised and found acceptable to *have*, b) it feels *safe* to have these feelings or problems, c) there are other *options* available in helping to deal with these and d) these behaviours (e.g., bingeing, dieting) will be available in the future if, and when they are needed.
3. Sentences beginning with 'I can't...' puts one in a position of helplessness. Sentences beginning with 'I should ...' puts one in a no-win situation. Sentences beginning with 'You make me ...', or 'It makes me ...', gives away one's power. Sentences such as 'I'm sick and tired of ...' are likely to come true, if said often enough.
4. One's body does what you want in that it responds to one's beliefs about it. This involves a radical restructuring of beliefs about the mind/body conflict found amongst those suffering from eating disorders. Refer to Appendix C.

Pleasure Members wrote a list of 10 pleasurable activities, 10 ways they could pleasure themselves, and 10 ways they could let others give them pleasure. This exercise aimed to increase the number and frequency of pleasurable events. A necessary component was to convince members that they *deserved* pleasure regardless of weight, shape, and eating behaviours. [Many individuals had difficulty in this exercise.

Assertiveness Instruction was given in the 'Broken Record Technique' for saying 'no'. The group divided into pairs and role-played saying 'no' in situations where they had difficulties. Partners changed after each pair of role-plays

in order that an increased number of practices took place. Successful role-players were asked to perform in front of the group and strongly reinforced for their success. [Some members found saying 'no' incredibly difficult, even during role-play. These members were given advocates who sat with them and said encouraging things to them during the role-play. These advocates were not allowed to communicate with the other partner. In one case it was necessary to role-play a situation where the individual could *not* say 'no' as in a situation where her child was being taken away from her, in order for her to learn to say 'no'. She claimed never to have said 'no' to any request in her 30 years of life.]

Homework As well as individual homework tasks, such as continuing to say "I choose ...', reinterpreting negative self-talk, and so on, participants were asked to carry out as many pleasurable activities as possible and to record these. Handout part IV was also distributed to be read and completed. (Appendix C).

B.1.6 Week Six

Sharing Circle This followed a similar format to those in previous weeks. Reports of behaviour change were strongly reinforced.

Homework A discussion took place on matters pertaining to homework which had not been raised during circle. [Many individuals had difficulties finding the time (?) to carry out pleasurable activities. These individuals set a task for themselves to partake in .... pleasurable activities the following week. Some members had noticed ways in which they prevented others from giving them pleasure such as, turning down offers, and refuting compliments.]

Affirmations Since at least two individuals in each group perceived that their binge-ing/purging behaviours were somehow connected with an ambivalence about relationships, the use of affirmations in this area was discussed, Appendix C. Each group had decided that an individual has a right to a good relationship regardless of her weight. Examples were cited, suggesting that 'we get what we think we deserve' in relationships that is, if someone has low self-esteem and feels unworthy of love, then the sort of person they attract will fit into these beliefs; if someone believes that all that men want from them is sex, then those are the men they will attract.

Resistance Suggestions were offered on ways of coping with the fear of changing and what one might do if one finds oneself 'resisting' trying out new ideas.

This involved use of affirmations such as, 'It feels safe for me, ..., to change.' (page 100) as well as looking for the gains to be had from *not* changing. One such gain is that it is often more comfortable sticking to one's old belief system, or, 'It's better to be right and miserable than wrong and happy.' Groups were reminded not to try to force themselves to perform by using 'I should ....' self-talk, and to avoid limiting themselves by saying 'I can't ....', but to use 'I choose ....' sentences instead. Members were again praised for allowing themselves to come to the group sessions when change had seemed so frightening to them.

Guilt A situation was described to the group, and members were asked to judge how strongly and for how long an individual should feel guilty ('should' used deliberately here) as a result of the outcome, and what should she do?

The situation was as follows: A woman was visiting her mother and was alone in the lounge. Arranged around the lounge were a number of ornaments very precious to the mother. As a child this woman had not been allowed to dance in the room in case she broke something. On this occasion there was some beautiful music playing and the woman, feeling very happy and carefree, began dancing. Unfortunately, she fell against a table and one of the precious ornaments was broken.

Discussion took place first in small groups and then in large circle.

[This task provoked a lot of discussion. Most members believed at least 24 hours of guilt would be appropriate, with some small groups suggesting up to 3 days. On the whole, whilst apologies and offers to replace the article were suggested, this was not deemed sufficient 'punishment'. It seemed that this group of women actively sought punishment for their perceived wrongdoings. Feelings of guilt were considered to be part of this punishment. Several women claimed that they would *always* feel guilty for their wrongdoing. The actual nature of the act i.e., that it was an accident, was irrelevant. The outcome was what was considered crucial.

After some time participants began to realise that it was *they* who decided how guilty to feel, and for how long, rather than guilt being something imposed upon them and therefore out of their control.

The usefulness, or otherwise, of guilt was questioned. How guilt as a feeling was learned during upbringing, was discussed, along with it's appropriateness for adults who presumably had already established some sort of moral code.

Appropriate and useful behaviour for an adult might involve:

1. Making an apology to the person or group (or self) concerned.
2. Making amends for what was done. For example, replacing a broken article, returning borrowed money, or, in cases where making amends is not possible, a substitute might be used, such as donating some money to charity, or doing a good deed.
3. Forgiving herself, that is, actively deciding that everything possible had been done to make amends, the lesson had been learned, and that was the end of the matter (more on forgiveness later).

Fear A list of alternatives as to what could be done by an individual who felt afraid, was generated by the group. Depending on the fear, these included sharing the fear with a friend, asking a professional for help, using affirmations, and getting more information.

Letter Those who had not done so during the week were asked to write a letter to themselves containing a lot of positive messages and affirmations. Those reticent were encouraged to play the 'as if' game and, write the letter 'as if' they really liked and admired themselves. Participants were then asked to self-address an envelope provided by the leader, who collected the letters and posted them. [In spite of expecting the letter, and knowing the contents, participants were amazed at how pleased they were to receive them.]

NB: This task was done with the purpose of allowing participants to see how powerful 'self-talk' can be. However, they were not told the reason for the task.

Polar opposite Chart Each person was asked to list 3–6 qualities they had disliked about each of their parents in a column down the left side of the page. In the next column they wrote the polar opposite of this quality thereby 'selfishness' became 'selflessness', 'violence' became 'passivity', and so on. In a third and fourth column a list was made of how the person 'acted out' both the qualities (3rd column) and their polar opposites (4th column). The purpose of this task was to gain insight into how parents' behaviour influences us, and how very often we carry out the same disliked behaviour, possibly in a different way, and/or carry out the polar opposite behaviour which is often no more desirable. [Participants were highly interested to find that they carried out some of the very behaviour they disliked albeit in different forms, and often went to the other extreme and became 'too passive' or whatever.]

To complete this task, every person found a quality that they *liked* which emulated from the original disliked quality. The group was used to assist in difficult cases.

Homework Participants were reminded that only one week remained of the course, and were asked to set themselves tasks according to what they felt they needed, or would get most benefit from. They were asked to report the outcome back to the group the following week. [Several members of each group were concerned that there was such a short time left. It was suggested that the group sessions were just a beginning and that 'digesting' the contents of the handouts might take months or even years. Furthermore, there was an abundance of information available in the big wide world which they would find when they needed it (affirmation).]

B.1.7 Week Seven

Sharing circle This was conducted as in previous weeks.

Homework Discussion. [This took longer than usual with both groups. Members raised many issues, possibly because Week 5 and 6 had covered a lot of ground, and more likely, because this was the last session. However, only three from each group had taken the opportunity to see the leader individually during the week.]

Anger This week's major topic was anger. Many individuals with eating problems claim not to feel anger. With many eating may take the place of expressing anger appropriately. An introduction stressed that anger was a normal and, on occasion, valuable emotion (See Appendix C, for more detail). Furthermore, it is just that - an emotion. Nothing more. It is the individual's choice whether to express her anger or not, and how to express it. Physiological reactions were discussed. Sex role differences in the acceptability of anger and ways of expressing anger were discussed. It was suggested that resentment is a kind of 'stored up' anger. Why eating is a good way of coping with anger was discussed. Other possible ways of dealing with it were generated by the group with the emphasis on constructive alternatives (following a problem-solving strategy). The effects of one's anger on others was raised. [Most members did not initially think that feeling or expressing anger was appropriate. Furthermore, without exception, they found it extremely difficult to deal with situations where others were angry, even when the anger had nothing to do with them.]

The topic allowed further discussion along the lines presented in assertiveness training for instance, that each person is responsible for her own feelings and not those of others. Step by step ways of dealing with anger constructively were suggested. These were:

1. Recognise that you feel angry.
2. Make it OK to feel like this.
3. Examine carefully *why* you are angry. Often it's for a different reason than you first think.
4. Consider the alternatives available to you in this situation. Which alternative is best for you *in the long run*?
5. Make it OK to carry out this alternative. If this involves doing nothing, realise that that is *your choice.*
6. After you have made your choice and acted on it, and there is nothing further you want to do, GIVE IT AWAY!

(Appendix C, part V)

Forgiveness The concept of forgiveness was introduced (refer to Appendix C, part V). It differs markedly from that held by many. Basically, it implies *choosing* to live without the anger, resentment or disappointment for the good of *oneself* rather than to make another feel better, or because one should. It involves a shrugging off of both physiological and psychological effects of anger, resentment or disappointment.

Suggestions on how this may be done were given (Appendix C, part V). Participants were asked to write down some of the old resentments that they had harboured. They were asked to choose several that they were now prepared to live without (since we often have perceived secondary gains from holding resentments, this task is not always easy). Using written affirmations and spoken affirmations participants 'forgave'. [Participants claimed to feel lighter after completing this task and many actually laughed. They expressed surprise that they knew which resentments they were prepared to give away and which they chose to hang on to for whatever reason.]

Discussion Interest was shown within each group for arranging a reunion. This was to be in three months time. Participants expressed the opinion that the course was too short, and, in particular, the subjects covered in Week 6 and 7 would be better dealt with over more sessions. Ideas were generated by the

group members about what alternatives were available for further learning, growth, improvement, or help. These included doing assertiveness training, or effective parenting courses, and reading.

Warm Fuzzy-wuzzies The children's story of the warm fuzzy-wuzzies was told. (within which the moral is that if one passes on positiveness, it will be returned ten-fold). Each person then wrote her name on a piece of paper. These were shuffled and redistributed. Each person wrote a positive comment on each paper in turn, relevant to the person concerned. Folding the paper each time prevented other comments from being read. Finally, papers were reshuffled and returned to the owner. Each paper contained nine comments including seven from other group members, one from the person herself, and one from the group leader. These were to be taken away and read after the session was completed. [Participants reported on much pleasure they received from those at the 3-month follow-up. Some had reread them regularly.] A sample of the leader's comments may be found in Appendix B.

Summary A brief summary of the course was given. In particular it was stressed that:

'You have a lot of power. Everything you do, you do by *choice* at some level, and with the very best of intentions, using the best choices available to you at the time.' (Appendix C).

Participants were thanked for their participation, and the course was concluded.

Note: Group 2 had three brief mental imagery tasks included in this programme, on Weeks 5, 6 and 7. (Appendix B, page 88).

B.1.8 Mental Imagery Tasks

The following mental imagery tasks[2] were given to Group 2 only, in sessions 5–7. A brief relaxation was given preceding each task. Participants were given the option of not taking part if they choose. Scripts were read by the leader.

A THE PERFECT MOTHER

As time passes I would like you to consider the following:

Each of us, in our own personal history has had many, many experiences, some of which we label as unpleasant... Those unpleasant experiences often form the basis...for later abilities...and skills...which people who have never been challenged by such experiences...fail to develop.... How pleasant it is ...to experience discomfort from the past... with the full realisation .. that you survived those experiences, and that they form a rounded set of experiences from which you can generate more adequate behaviour in the present, ...and how well you survived those things so that they need never happen again .. and realise, how pleasant to remember how unpleasant...some of our previous experiences have been and know you have all the necessary skills to build a foundation which will be a solid structure on which to build new ... and more satisfying future behaviours just as when you stood on your own two feet for the first time you were building the foundations ...which would later serve ... as the basis for your own walking ... and running ... with delight and know that your unconscious mind could build that foundation quickly *or* it could build it slowly, but in either case it must build it *thoroughly* so that it doesn't collapse at a later time ... Because the choices that you want in your future behaviour .. must have all the necessary ingredients available ... at the unconscious level ... And in order to be available they will have to have a solid structure of understanding... and the necessary elements to make that behaviour available ... to you as a human being. And the choices come from you, and from your own unconscious processes .. there's no need for it to come from anywhere else ...while you sit there ... your unconscious processes ... have kept your heart beating ... have kept you breathing ... have kept the blood flowing through your veins, ... have done hundreds of other things that your conscious mind is not even aware of ... the importance of this ... is realising that you can trust your own unconscious processes ... to take care of you.

[2]No formal assessment of subjects' ability to perform mental imagery tasks was made, as all had successfully completed the Eidetic Parents Test and the Self-image test

When you walk down a busy street .. and your mind is lost in thought, you automatically ...stop at a red light ... even though you are engaged in internal activity, when the light changes ... you know that it's time to proceed ahead. And you can always trust these unconscious processes .. to do something .. which is beneficial .. and useful ... And its not really important why it didn't happen in the past. It's only important to know ... that its possible in the future, that your unconscious mind continues to demonstrate to you ... in new behaviours .. its vast potential to notice changes in your ongoing behaviour ... now and in the future.

And that part of you who is the perfect mother knows that *whatever* you do is good, part of learning and growing and living and she cares for you and loves you always.

Now I'm going to count backwards from five to one and when I reach one allow your eyes to flutter open, as you feel refreshed and renewed and ready to begin again, learning something new, five, four, three, two, one.

B ALTERNATIVES

I want you to go inside and thank that part of you which has been doing its best to help you by bingeing... Tell that part you now know that it has been acting with the very best of intentions and that you now wish to co-operate with it. Also thank those parts of you which has been vomiting and using laxatives or dieting ... These parts, too, have been acting with the very best of intentions.... Now, I want you to ask these parts to give you a sign that they are prepared to communicate with you ... You may feel hot, or cold, tingly or have some other physical sign at this point ... Can everyone feel a sign that these parts are prepared to communicate? [Each participating member[3] of Group Two (n = 6) was asked in turn whether she felt a sign, and what that sign was. All individuals felt some physical sensation.]

Take that sign to signal a 'yes' response. The absence of the sign will signal a 'no' response. Thank those parts again for communicating with you ....Now, I want you to ask those parts if they are prepared to co-operate in helping your creative mind to think of more alternatives- for ways for you to think and feel instead of bingeing and vomiting... [All but one participant felt the 'yes' sign at this point. The remaining participant was told to tell these parts that she would use them whenever the need arose, and that she appreciated

[3]Two members chose not to take part in this exercise.

their help, Also that she would check with them that the new behaviours were acceptable before using them. At this point, she felt her 'sensation'.]

Now, I want you to go into your creative mind and ask it to think of five alternative behaviours which you could use instead of bingeing, and five alternative behaviours you could use instead of vomiting, or dieting. These behaviours must be acceptable to all your parts. Ask your creative part to let you know when the task has been completed ... raise your right hand when you have finished. [This took several minutes. One participant had not finished after 3–4 minutes. She was allowed to ask her creative part to continue the task during the night's sleep.]

Thank your creative part for its assistance. Now I want you to ask these parts of you which look after you by bingeing, vomiting and dieting, to check over the alternatives your creative part has suggested. If it finds some acceptable alternatives, ask it to give the 'yes' signal [All participants received the 'yes' signal.]

Now, once again thank that part of you for its co-operation .... Now, ask all parts to check these alternatives to see if they are acceptable ... If not, rest assured that they will not be used.

From now on, you may find yourself acting in different ways than usual, especially in situations where previously you might binge, or vomit, or use laxatives, or diet. Your creative part will continue to come up with alternative behaviour which will be checked by your other parts for its acceptability. Remember though, that your bingeing, vomiting parts will always be ready to help, should you so desire them.

Once again, thank all parts of yourself for their loving co-operation, .. and in your own time come back to the fully alert state.

C INTEGRATION

Please sit with your hands upturned on the arms of the chair. Remember a few weeks ago, you were asked to imagine your big self and your thin self? Now I want you to once again imagine your thin self ... Has everyone got a clear picture of this self? ... [Affirmative] Notice what she is wearing .... how she is standing or sitting .... the expression on her face ... how she is feeling ... Now imagine she is standing on the palm of your upturned hand. ...just nod when I call your name if you have her there....[Affirmative] Now, I want you to image your big self .... notice what she is wearing , how she is standing ... what her facial expression is .... can you see everything about

her clearly? [Participants asked by name, in turn]. Now I want you to put her on your other upturned palm ... Is she there? [Affirmative]. On the one hand you have your big self, and on the other, your thin self.... Now, in your own time, I would like you to slowly bring your hands together. When they are together, intertwine your fingers. Begin now ... take your time. [This took some time. Two of the eight participants opened their eyes at this point and did not want to carry on. After about five minutes, the two members whose hands were not yet joined were told 'your hands are slowly coming together now'.]

In your own time, just return to a very relaxed but alert state.

B.2 Examples of fuzzie-wuzzies

YOU'RE POSTIVE ENERGY HAS BEEN VERY UPLIFTING.

I like your Dale, because you take risks + trust yourself enough to.
I think you're rad — the way you can laugh at everything. You are a fun person to know.

I have enjoyed meeting you. I find you a very interesting person and a warm caring one too.

It is nice to have some one who cares enough to help us to work out our problems. Thank you.

I had a lot of fun being in the group & certainly learned a great deal about myself. What I like most about having had you in the group was that your sense of humour helped to deal with the heaviness & self-loathing floating in the air.

The sort of person who says "have a nice day" and really makes you feel like having one — neat.

I REALLY ADMIRE YOUR STRONG PERSONALITY AND KNOWLEDGE

Because you believe the best - you are the best

How can I ever thank you for everything you have done for me. Words would just Not be enough but many thanks anyway!

Caring - Sensitive person.

you have helped me be ME and I thank you for that. I now feel that I like myself.

All I can say is great. I've gained a lot from this course, & I'm glad I came & I still find it hard to believe you are 37!

I've appreciated the way you've "led" the group - thanks for lots of interesting input.

Was really open and friendly with the group.

PTO.

Thankyou. Even though I felt unsure. You've made me feel stronger and positive. I love you've attitudes and ways. and see qualities I admire

Appendix C

Handout Materials

DISCUSSION GROUP.

Philosophy __ Everything you do can be seen as some part of you doing the very best it can for your survival and wellbeing.

Some Facts.

(1). DIETS do not work for 98% of people for weight-loss purposes. However, they are great for temporarily raising your self-esteem, proving that your mind can sometimes control your body. They're also great for reminding yourself how 'virtuous' you can be. "I've had a good day, today." Long fasts are also reknowned for producing 'spiritual' highs.

Diets are also useful for temporarily relieving feelings of anxiety depression, or anger, by focusing your mind on less disturbing thoughts such as how you look, and on such things as counting calories, planning menus, and fantasizing how happy you will be when you are __ kgs.

(2). Binging after food deprivation, ie dieting, fasting, vomitting, or even the thought of possible food deprivation, is a normal deep-rooted survival mechanism shared by all animals. If you have been on a restrictive diet, fasting, or even planning to go without food, urges to binge are the normal consequence.

Binging can also be useful for 'nurturing' yourself, rewarding or punishing yourself, and protecting or distracting yourself from situations or feelings you might otherwise have difficulty coping with. Like dieting its also a great way of structuring your time.

(3). VOMITING, laxitives etc can bring great relief from feelings of 'overfulness' after binging and some relief from the guilt attached to the binging preceding it.

Vomiting is also time consuming, and along with binging helps structure your time, especially when coupled with rituals involving cleaning of bathroom, showering etc.

Both vomiting and binging are also useful behaviours you could use to make yourself feel worthless, ugly, etc etc, if thats how you choose to feel at the time. It can feel safer to feel like this, especially if its a very familiar feeling, than what you might otherwise feel. This is a very useful protection.

Whilst dieting can sometimes be done with an "I'll show them" motive, dieting, binging, vomiting, or being overweight or underweight, can be indirect ways of trying to get back at someone in your past or present.

Doing something forbidden can be very rewarding.

Doing something secret can be very rewarding.

Since each person has her own reasons for these behaviours, it may be worthwhile spending some time on compiling your own list..

A) I FIND BINGING USEFUL BECAUSE:

B) I FIND VOMITING (OR DIETING) USEFUL BECAUSE:

C) SOME ADVANTAGES OF BEING BIGGER OR SMALLER WOULD BE:

BIGGER	SMALLER

D) SOME DISADVANTAGES OF BEING BIGGER OR SMALLER WOULD BE:

BIGGER SMALLER

E) I FIND MY PRESENT WEIGHT USEFUL BECAUSE:

F) I FIND EFFORTS TO 'CONTROL' MY BEHAVIOUR USEFUL BECAUSE:

CHOICE.

By now, hopefully, you will be able to see that none of these behaviors is 'good' or 'bad' but that at some level you choose to do each for very valid reasons.

If you do not yet see this, then continue to say "I choose to eat this because.....", "I choose to vomit now because.....", after you have already made the choice to do it anyway. Try not to put value judgments on your decisions. At some level they have been made with the very best of intentions.

If you find difficulty in saying "I choose....." in an attempt to avoid responsibility, you may like to try saying "I choose not to take responsibility for my actions at present because....."

Here are some more things to think about:

G) THE DISADVANTAGES OF TAKING RESPONSIBILITY FOR MY ACTIONS ARE:

H) THE ADVANTAGES OF TAKING RESPONSIBILITY ARE:

CONFLICT

One of the characteristics of eating problems is ambivalence or conflict. Here are some examples you may recognise.

Wanting to binge V wanting to diet
Nourishing yourself by eating V negating this by vomiting/dieting/laxitives
Needing to feel good V thinking you deserve to feel bad
Not liking your weight V doing everything in your power to remain that weight
Wanting to say "no" to someone V thinking you have to say yes
Wanting to ask for something V thinking you dont have the right

I) SOME OF THE CONFLICTS I HAVE ARE:

Conflict re discussion group.

Although you are choosing to take part in this group, you may experience mixed feelings and confused reactions. This is normal. Change can be frightening, especially if you have been used to behaving in certain ways for many years. Also, your eating behaviours have been very useful to you eg as a way of indirectly saying "no" to others and an attempt at 'controlling' your life (refer to your own lists on page 1). Because of this you may find yourself avoiding doing the very things which you think might be of most help to you in the group. This can be frustrating for you, but becoming aware of this conflict can be very helpful.

'CONTROL'

Desire to be in control, fear of losing control, fear of others controlling you, fear of one (less desirable) part of you controlling another part, are often central issues to those seeking 'control' through their eating behaviours.

A useful thing to realize is that one part of you is 'in control', ie making choises, whatever you do. Noone can make you do anything, even at gunpoint. If you choose not to do what the gunman wants, of course you may risk death, but it is still your choice.

'SHOULD'

What happens when one part of you tries to 'control' another part? eg you say "I should do the housework". You have put yourself in a 'no-win' situation. If you do the housework you may feel put-upon, or resentful, certainly unlikely to be happy about being bossed around like that. If you don't do the housework you may feel guilty, lazy, remorseful etc.

However, if instead you say (on noticing the housework) "I can choose to do the housework now, or I can choose not to do the housework now," you will either find yourself happily doing it, or happily doing something else without guilt. This change in the language you use in 'self-talk' can have a profound effect on your life. Whatever you choose to do is done freely and wholeheartedly. You no longer have any cause to berate yourself, call yourself names, or make yourself suffer for not responding to the "I should....." command.

ASSERTIVENESS

Once you realize that everything you do is your own choice, you are free to enlargen your repetoire of possible choices. For example, if you have always chosen not to say "no" to others, you may choose to learn how to say "no". This does not mean that you have to say "no", but merely that you have more choices than before.

This also applies to choosing to learn how to ask for things you need, or want, and how to accept positive and negative feedback from others (ie compliments and criticism), communicating your feelings to others, or any other skills you may wish to include in your repetiore.

THIS COURSE IS ABOUT CHOICE.

It offers possibilities for you to enlargen your repetoire of choices. Your behaviours - binging, vomiting, dieting or whatever, have been choices you have made for valid reasons. Furthermore, they have been the best choices you have been able to make at the time. They may still at times be the best choices for you to make in the future. Having new choices doesn't mean throwing out old behaviours but adding new ones.

SOME CHOICES I WOULD LIKE TO BE ABLE TO MAKE ARE:

K) THINGS I WISH TO GAIN FROM PARTICIPATING IN THIS GROUP ARE:

L) WAYS I COULD CHOOSE TO DO THIS ARE:

AFFIRMATION

Say as often as possible - "Everything that I, _____, do, I do by choice."

Or, - "Everything that I,_____, do, I choose to do willingly."

M) OTHER THOUGHTS WHICH MIGHT BE USEFUL ARE:

Poem for everyman

I will present you
parts
of
my
self
slowly
if you are patient and tender.
I will open drawers
that mostly stay closed
and bring out places and people and things
sounds and smells, loves and frustrations, hopes and sadnesses,
bits and pieces of three decades of life
that have been grabbed off
in chunks
and found lying in my hands.
they have eaten
their way into my memory,
carved their way into
my heart.
altogether—you or i will never see them—
they are me.
if you regard them lightly,
deny that they are important
or worse, judge them
i will quietly, slowly,
begin to wrap them up,
in small pieces of velvet,
like worn silver and gold jewelry,
tuck them away
in a small wooden chest of drawers
and close.

DISCUSSION GROUP - PART II.

Title: You are what you believe you are.
OR, What colour glasses do you choose to wear to look at the world? Yourself? Others?

Suppose, as a small child Ann had been told many times that she was lazy. She may have come to believe this and now often reminds herself how lazy she is. At every opportunity eg when she doesn't do the housework, she says "that proves it, Im lazy". Alternately, she may be frantically busy all the time in the attempt to prove to herself she is not lazy. Or, she may alternate between these two.

WHAT BELIEFS DO YOU HAVE ABOUT YOURSELF?

All you need to do to find out isto listen to the things you say to yourself (self-talk), day by day. Do you say accepting, encouraging, and positive things? Or are you constantly criticizing, bossing, and rejecting yourself?

A) Some of the things I have been telling myself are:

Negative	Positive

The world will affirm your beliefs.

If you believe you are eg unattractive, unloveable, worthless, unable to finish things, have bad luck, are hopeless, will never change, etc etc, everything you do or others do, you will interpret in such a way as to carry on believing these things.

For example, "You look nice today", could be interpreted as "I wonder what he wants?" or, "He wouldn't say that if he really knew what I was like inside", or, "What an idiot to think I look nice - what bad taste!" You might make a face, shrug, ignore him, or say something sarcastic. He decides not to bother complimenting you in future. You get to affirm your beliefs - ie prove you are right!

However, if you believe you are attractive, loveable, a worthwhile person, someone who attracts good fortune etc, you will interpret everything you do, or others do, in such a way as to carry on believing these things. For example, "You look nice today" becomes "Nice of him to say so. Yes, I do look nice. I feel good, too." Your reply , "Thanks", will encourage that person and others to compliment you in the future. You get to affirm your positive beliefs.

B) What beliefs would I like to have about myself?

I'd like to believe that I'm:

You can come to believe anything you want.

Just as you have created, and continue to affirm negative beliefs about yourself, and the world, you also create, and continue to affirm positive beliefs about yourself and the world. Its your choice!

HOW?

First, REINTERPRET!

Whenever you find yourself saying something negative to yourself, think of a positive way you could interpret the same situation. (NB - You don't have to believe this interpretation).

Eg 1) You watch TV all afternoon:

"I'm so lazy" could be reinterpreted "I'm really pleased I'm the sort of person who is able to relax."

Eg 2) Someone shouts at you. "What have I done wrong, now" becomes "She seems to be having a bad day!"

Eg 3) You sit alone at home:

"Nobody likes me" becomes "Great, a chance to be by myself. Now, what would I like to do?"

Play the 'Reinterpret' game as often as possible. Remember, you don't have to believe your new interpretations, and its great fun exercising your creative abilities.

Second, play the 'AS IF' game.

To play, all you need to do as act 'as if' something on your list (B), is actually true. EG, suppose you would like to believe you are attractive. Next time someone compliments you on your appearance, act 'as if' you believe you are attractive. You may smile and say thank you, or whatever you think you might do if you believed you were attractive. NB, you don't have to believe your responses - its only a game. Try little things, then more ambitious ones. There is no way to lose this game, and its fun to see 'how far you can go'.

Eg 2) Suppose you would like to believe you are a loveable person. Take some time to act 'as if' you are a loveable person. You may decide to treat yourself to a luxurious bubble-bath, or in some other act 'as if' you want to show yourself how loveable you think you are.

Eg 3) Suppose you would like to believe you can change things in your life. Act 'as if' you can - perhaps by rearranginging your room, or wearing a different colour from usual, or.....

Third, use AFFIRMATIONS.

An affirmation is a thought which you consciously plant in your mind. If you repeat a thought enough you will come to believe it. You can consciously create your future self-image, what you think, and how you feel. Just as what you think and feel about yourself now is a result of past thoughts, what you think and feel about yourself in the future will depend on what thoughts you have now.

Instead of replaying (and therefore affirming) all your old beliefs. you can make a conscious decision about what you will come to believe instead.

The first thing to affirm is that its OK to be the way you are now.

First write a list of all the things that you want to change in your life. This is not a list of goals or things you want, but things you already have that you don't want. EG, my poverty, my overweight, my not having a relationship etc.

C) My list of things I want to change:

NEXT STEP. Draw a circle around the item that you want to change the most. Now compose an affirmation for yourself in the form:

It is OK for me, _____, to _____.

eg It is OK for me, Ann, to be poor.
It is OK for me, Nancy, to be overweight.
It is OK for me, Katy, not to be in a relationship.

This affirmation is often an excellent way to begin solving a problem. It is much easier to solve any kind of a problem when it is OK with you to have the problem to solve. Please understand that you will not agree with the statement in this affirmation at first. For this reason use a 'response column' to write down your reactions, objections, and considerations about the affirmation. This will clear them from your mind. I suggest you write the affirmation in three persons eg "I, Ann", "You, Ann", and "She, Ann".

Here is how it might look. (Add your name to the first ones too).

AFFIRMATION	RESPONSE COLUMN
It is OK for me to be overweight.	I hate being overweight.
It is OK for me to be overweight.	NO!
It is OK for me to be overweight	I wish this were true.
It is OK for me to be overweight	I'm starting to feel angry.
It is OK for me to be overweight.	I don't want to do this.

After filling about one-third of the page, switch to the second person.

Nancy, it is OK for you to be overweight.	No one ever told me this.
Nancy, it is OK for you to be overweight.	No one will love me.
Nancy, it is OK for you to be overweight.	Wanting people to love me when I don't love myself.
Nancy, it is OK for you to be overweight.	This is asking a lot.

After filling about two-thirds of the page, switch to the third person.

It is OK for Nancy to be overweight.	My mother always worried about my being overweight, yet she wanted me to eat, too.
It is OK for Nancy to be overweight.	I'm beginning to feel a little better about this.
It is OK for Nancy to be overweight.	I'm still a little afraid that focusing on this problem will make it worse. Maybe I'm better off ignoring it.

As you write this affimation over a period of time, the responses you write will become less and less powerful. This is because your mind is beginning to accept the affirmation.

How to use affimations effectively.

Write or type with responses (as above).
Write or type without responses.
Put it on a card to carry around.
Make a sign and put it where you will see ot often.
Make a tape.
Work it into a conversation.
Say it to yourself in a mirror.
Say it to someone who will agree.
Say it to someone who will not agree.
Say it mentally.
Scream it.
Chant it.
Sing it.
Develop your own ways.

More about affirmations next week!

DISCUSSION GROUP - PART III.

Food for thought.

We have spent some time in the groups discussing the power of words, especially in the form of thoughts, or 'self-talk'. Here are some common expressions in the english language which you, unknowingly, could be responding to. Think about each carefully. They all relate to overeating, binging, dieting, fasting, vomiting, using laxatives, and being either over- or under-weight.

I am WEIGHED down with responsibility.
I am EMPTY of emotion.
I am FILLED with longing, (or remorse, or fear).
I am CHOKED UP with anger.
I am HEAVY with guilt.
I am EATEN UP by grief.
I am CHEWING over my problems.
I am SWALLOWING my pride.
I am CONSUMED with sadness.
I am HEAVY with remorse.
I am CARRYING A LOAD of guilt.
I am CHOKED UP with anxiety.
I am HUNGRY for revenge.
I am SHITTING myself with fear.
I can't STOMACH .....
I am STARVING for affection.
I am FULL of hate and resentment.
I am BLOCKED UP, CLOGGED UP with emotions.
I am SICK with envy.
I am SICK and tired of .....
I am EMPTY of emotion.
I am EATEN UP by resentment.
I have trouble DIGESTING new ideas.
I am FED UP with my mother, my job, my husband, myself,.....

If you have a problem, do you try to 'SPIT IT OUT', CHEW IT over, or let it WEIGH HEAVILY on you.

Do you prefer to have food for thought or do you often choose to think of food instead?

Use words to work FOR you.

Tick the expressions at the beginning of this handout which you think may be connected with your relationship with food, digestion etc. Use affirmations to seperate the feelings from your eating behaviours.

Some examples of your affirmations might be:

"Its OK for me,_____, to feel angry, regardless of whether I choose to eat or not".

"Its OK for me,_____, to feel afraid, whether or not I choose to take laxatives."

"Its OK for me,_____, to have and feel needs, regardless of my eating patterns, or my weight."

This exercise will help you to realize that your food-related behaviours don't actually solve any underlying problems or remove any underlying feelings, you may have, although they have been very useful to you as a way of coping with these problems or feelings. Rest assured that they will continue to carry out this worthwhile job until:

(1). Actually having these problems becomes acceptable to you, eg, "I feel guilty", "I feel afraid", "I feel resentful", "I feel grief", etc are considered by you to be valid feelings, and part of that which make you a human being, a unique person.
(2). You feel safe to have these feelings. Affirmations are useful here. Eg."It is safe for me,_____, to feel angry."
"It is now safe for me,_____, to fully feel my grief about ....."
"It is safe for me,_____, to recognise my fear."
(3). You recognise that your food-related behaviours are only some of many options available to you for coping, or creatively changing these feelings.
(4). You find other acceptable options which achieve the same purposes your food-related behaviours achieve.
(5). You accept that your food-related behaviours are useful and will always be available to you when and if you need them.

More about the power of words.

Any sentence beginning 'I can't....." puts you in a position of helplessness.
Any sentence beginning 'I should.....' puts you in a no-win situation.
Any sentence beginning with "You make me.....", or, "It makes me....."
Any sentence such as "You are a pain in the neck (back, butt)", "You give me a headache", "You make me sick", "I'm sick and tired of.....", are likely to become true if you say them often enough, just as you could be unwittingly be acting out some of the above thoughts.

Your body does what you want.

Do you know that every time you think negative things about your body (or any other part of yourself for that matter), your body responds to what it thinks you want? For example, if you say "Yuk, I hate my body. Its fat, repulsive, and ugly." your body will do its utmost to prove you are not a lier, and try and be what you are saying it is. It is faithfully responding to the commands: "Body, be fat! Body, be repulsive! Body, be ugly!"
For years, you may have been telling yourself, "If I control my body, then I will be happy. Then I will love myself." And all these years you have been proving to yourself that you are a failure, and withholding respect and love from yourself.
And all this time, your body has been your loyal friend in supporting your beliefs.

AN AFFIRMATION: "I,_____, thank my body for doing what I asked it to do for all these years, and I,_____, forgive myself for thinking negative thoughts about my body, when it has actually been my friend. I,_____, also forgive myself for withholding love from myself."

EXERCISE - Any exercise done solely to lose weight won't do it in the long run for the same reasons as above. If you aren't exercising for pleasure, it is self-torture, and just doing it reminds you that you don't like yourself the way you are. Your body will respond accordingly.

AN AFFIRMATION: "I,_____, am exercising solely for enjoyment."

More about this next week!

Pleasure yourself.

Make a list of ways you like to recieve pleasure. Remember, you have five senses, by which to receive pleasure, by seeing, smelling, tasting, touching and hearing. Try to include something for each one on your list. There are also other ways, such as remembering or imaging.

HERE ARE MY TEN GREATEST PLEASURES.

TEN WAYS I COULD LOVE MYSELF ARE:

TEN WAYS I COULD LET OTHERS LOVE ME ARE:

DISCUSSION GROUP - PART IV

Your body always cooperates with your mind.

If you say "I don't like my body", your body must do whatever you don't want it to do, in order to please you.

If it is overweight, it is because on some level you want or need it to be overweight (similarly for binging, vomiting, dieting, etc).

Check back to List A in the first handout.

Make a list of affirmations for yourself from this list.

Eg Suppose one reason you are overweight is to avoid relationships. Your affirmations might include:

"I,_____, can say no to relationships, regardless of my weight."

"I,_____, have pleasing relationships, regardless of my weight."

"I,_____, attract loving people."

"I,_____, deserve to be loved, regardless of my eating behaviours."

"I,_____, feel safe, whether or not I choose to have relationships."

NB. Don't forget to occasionally thank your body for so loyally doing what you want it to do.

"Thank you, body, for doing what I want you to do."

Also be aware that your body is a great communicator. For example, if you suddenly start binging, this is a message to you that something important is going on for you at this time. You may wish to thank your body for communicating with you in this way. You may also wish to thank that part for looking after you in this situation. You may also feel safe to look a little deeper into what is going on, and what other resources are available for you use.

SOME USEFUL AFFIRMATIONS:

"I,_____, now feel safe exploring my feelings."

"I,_____, have the right to feel."

"I,_____, feel safe when I am _____."

"I,_____, am a great person whether or not I choose to feel _____."

SOME HINTS ON AFFIRMATIONS.

Short affirmations are often more effective, especially if you are writing them.

Use the present tense rather than the future. "I am....."

Use only words that have positive meanings to you. Eg "I cope with pitfalls and hardships", can be better worded "I enjoy my life", or, "I am a resourceful person", or, "I am constantly learning positive things about myself."

Write or say affirmations in each of the three persons -"I am____", "You are_____", "She is_____."

Include your name unless it feels clumsy.

Those affirmations to which you have the most responses are the most useful.

Include some you really enjoy just for fun. Don't be afraid to be really ultra-positive in your affirmations.

If you have a negative affirmation on your 'fridge such as a picture of a fat person, a calorie chart, or anything else which affirms that you are less than perfect, replace it with a really positive one, eg, "Open me and let my contents fill you with delight. You deserve it."

Affirm that you deserve plenty of the best by making sure you favourite foods are readily available whenever you choose to partake of them.

Write yourself a loving letter, and actually post it.

Here are some other examples of affirmations:

1. It is OK for _____ to _____.
2. I love everything about _____.
3. _____ is infinitely good.
4. _____ is _____ enough.
5. I am fine whether or not _____.
6. _____ exists for my convenience and pleasure.

7. I am infinitely grateful for _____.
8. I forgive _____ for _____.
9. _____ is pleasantly amusing for me.
10. I receive infinite pleasure and infinite benefit from _____ _____.
11. I am grateful for the existence of _____.
12. _____ inspires me.

not 'wrong'. There is now no need to carry this guilt around with you any more. If you are still not clear on this, try an affirmation such as:

I,_____, forgive myself completely for _____."

SOME OF THE THINGS I FEEL GUILTY ABOUT ARE:

USEFUL AFFIRMATIONS ABOUT THESE ARE:

Resistance

If you feel that part of you is 'resisting' trying out new ideas, or allowing yourself to change, ie 'sabotaging' all your efforts, remember that that part, too, is doing the best it can for you. It may be that the payoffs for changing aren't as great as the payoffs for staying the same at present. One big payoff making sure nothing works to change you, is that you get to affirm your belief system is right. Better to be right and miserable than wrong and happy. This is a valid payoff. We all need a belief system to be able to function, eg to know it will be light for a certain number of hours tomorrow, that people will have the same names, and behave in basically the same way as usual etc.

In your belief system you have some fundamental beliefs about yourself, and your relationships with others. One may be that 'nothing can change the way you are'.

SOME BELIEFS I HAVE ABOUT MYSELF ARE:

You may find you need to modify some of your beliefs very slowly. There is no time limit! For example, 'nothing can change the way I am' may be acceptable to you reworded as 'nothing can change the way I am unless I am ready', or 'nothing can change the way I am, except me'.

Another payoff for avoiding change is that it can be very frightening to contemplate changing. Eg, if your eating 'problem' has been a big part of your life for many years, who would you be without it? What would you do? How would you act? These fears are valid and justified. The part of you that is 'resisting' is merely making sure you don't change too fast, and experience too much fear.

SOME USEFUL AFFIRMATIONS MIGHT BE:

"I,_____, am free to change when I am ready"
"I,_____, am constantly changing at my own pace."
"I,_____, change safely."
"I,_____, am fully responsible for my own changes."
"It is OK for me,_____, to take as much time as I need."

GUILT.

Guilt, like hate, can be a cover for fear.

Very often we can feel guilty about something long after the person we have supposedly 'wronged' has forgotten about the incident. Your guilt is not helping that person and it certainly isn;t helping you.

Sometimes guilt can be a habit learned in childhood, and like any habit, it can be changed when you choose to be without it. This would perhaps mean giving up a familiar and therefore safe way of feeling (even when you don't like the feeling). If you now feel ready to give up feeling guilty, here are some useful steps you could take.

1. Apologize to the person you feel you have wronged (this may even be yourself). This is possible face to face, by letter or in some other way your creative mind may think up (eg if the person is dead, you might try writing your apology on paper.)

2. Make amends for what you think you have done. This might involve replacing what was broken, returning the money you borrowed 20 years ago, or whatever. It is not possible to change the past. It is often impossible to 'make amends'. If this is the case then your choice is to accept this, or to continue to suffer. Be aware that the suffering is for nobody else's benefit except your own.

3. Forgive yourself! You have now taken full responsibility for your actions, and done everything possible to 'put-right' the situation. Furthermore, you have learned already what you needed to learn from your actions. You may even decide that, given the circumstances, you behaved in the best possible way you knew how, and therefore what you did was not 'wrong'. There is now no need to carry this guilt around with you any more. If you are still not clear on this, try an affirmation such as;

I,_____, forgive myself completely for _____."

SOME OF THE THINGS I FEEL GUILTY ABOUT ARE:

USEFUL AFFIRMATIONS ABOUT THESE ARE:

FEAR.

What can you do if you realize you are afraid? This depends on your circumstances. When faced with a wild tiger it might be appropriate to run away. Sometimes, it is more appropriate to face your fears. Often it helps to tell someone about them. If you prefer, try writing down all the things you are afraid of. Write down the worst possible things that could happen if your fears were realized. What would you do in that situation? Do you think you could survive? Then what would you do?

Have a close look at your list. Are the consequences really as bad as you first thought?

SOME USEFUL AFFIRMATIONS MIGHT BE:

"It is safe for me,_____, to feel afraid."

"I,_____, learn from my fear."

"I,_____, am a resourceful person."

"I,_____, see life events as an opportunity to learn positive things about myself."

The universe is a safe place for me."

"I,_____, feel safe."

DISCUSSION GROUP - PART V.

ANGER.

The first thing to realize about anger is that it is a normal and valuable human emotion. When we feel angry, our bodies are filled with energy and ready for action. This has been useful for the survival of the human race.

Many of us, especially females, have been brought up to believe it is 'wrong' or unacceptable to be angry, or show anger. Sometimes this has been because our parents didn't know how to cope with our anger, or were uncomfortable with it. Often they found it difficult to feel and express it appropriately themselves. Sometimes, especially if they expressed anger as violence - either verbally or physically, they may have been very afraid of anger, and tried to prevent you from feeling it, or showing your feelings. Your anger may be suppressed and you instead carry around a load of resentment and guilt.

You in turn may feel uncomfortable around others who are angry, and may even go out of your way to stop them feeling angry even when its not directed at you. You may also prevent yourself from feeling or expressing anger for fear that other people will be hurt, uncomfortable, violent or dislike you as a result.

HOW I FEEL ABOUT MY ANGER:

HOW I FEEL ABOUT OTHERS BEING ANGRY:

SOME USEFUL AFFIRMATIONS ARE:

"It is OK for me,_____, to feel angry."
It is safe for me,_____, to feel angry."
"I,_____, allow _____ the right to feel angry."
"I,_____, feel safe in the presence of another's anger."

WHAT DO I DO WITH MY ANGER?

First of all, recall some situation in which you felt angry. Now be aware of your body. Do you feel tense anywhere? Your neck? Your jaws? Your stomach? One way of dealing with anger is by suppressing it and storing it in our bodies. Resentment is a kind of 'stored up' anger, a grudge you have never given up. One way of suppressing anger is by eating a lot. This uses up the energy released by anger as the digestive system requires a greater blood supply. Eating a lot can also release chemicals called endorphins (as can physical exercise). Endorphins are similar to morphine, a drug which is used as a painkiller. Thus any feelings you may have can be numbed - temporarily, anyway.

Another way of dealing with anger is to redirect it. If it feels dangerous to feel angry with another person, it can feel safer to redirect it towards yourself. This is easy to do! Simply do something of which you disapprove eg binging, and become angry with yourself. However, maybe you would like more choices now. You will need to decide what is appropriate and acceptable for you. Say you decided that it would be good to be able to express your anger in a constructive way to the person concerned (violence, sarcasm, snide remarks etc are not usually useful to either party).

For example, you might say: "John, I've been feeling really angry about some of the things you said to me last night."

Here you are (i) allowing yourself to <u>have</u> the <u>feeling</u>.

(ii) taking responsibility for your feelings. NB "You <u>made</u> me angry" is <u>not</u> taking responsibility for <u>your</u> feelings.

(iii) sharing your feelings with John.

Possible Outcomes: John may be grateful that you trust him enough to discuss this matter. He may appreciate the chance to say "I'm sorry" for something he felt bad about. He may find it hard to cope with the fact that you're feeling angry, especially if you have never shown anger before.
ALL of these reactions are John's responsibility. You are responsible for your own feelings and not his.
SOME USEFUL AFFIRMATIONS MIGHT BE:
"I,_____, feel safe as John has his own feelings."
"I,_____, am calm in the knowledge that I am true to myself."

Sometimes it may not seem appropriate to share your feelings. It may be useful examining why it is not appropriate eg why you are choosing to live with a violent person, why you think your honest feelings might 'damage' the other person etc.

DEALING WITH ANGER CONSTRUCTIVELY.

1). Recognise that you feel angry.
2). Make it OK to feel like this.
3). Examine carefully why you are angry. Often its for a different reason than you first think.
4). Consider the alternatives available to you in this situation. Which alternative is best for you in the long run?
5). Make it OK to carry out this alternative. If this involves doing nothing, realize that that is your choice. Recognising this is important. You have choices in every situation!
6). After you have made your choice and acted on it, and there is nothing further you want to do, GIVE IT AWAY!

FORGIVENESS.

Once you have let yourself feel and acknowledge your anger, and decided whether or not, or in what way to act on it, you will feel a great deal of relief. However, there is one more important step to take. This is a decision that you no longer need or want that particular anger and its effects on your body and mind. This is a 'giving away' of the anger, or 'f rgiving'.

Some people believe that forgiving means saying something to the other person to make them feel better. "Its OK, no problem." Some people think that forgiving means that you think what the other person has done is alright after all. Some think that this is arrogant. And some believe that you should forgive the other person - either out of kindness, or because of religious beliefs etc. It is also easy to hope that in forgiving someone they will behave differently toward you.

What I mean by forgiveness here is none of these things. It has nothing really to do with the person you are 'fogiving'. It is wholly self-centred, is completely your decision - ie you can choose to forgive or not, and is done for the sole purpose of looking after one person - YOU!

It involves some sacrifice on your part, especially forgiveness involving old hurts. You have to be prepared to give up all the pain you've been carrying with you for years, the tension in your muscles, the old emotions - and sometimes we get a lot out of holding old grudges, especially when we want to feel sorry for ourselves. It is a lot to give up!

There is also likely to be a lot of fear involved. What would you be like without all that anger, hurt, or resentment? How would it feel if you want to feel sorry for yourself and you can't think of any reason because you've forgiven everyone (including yourself)?

First, remind yourself again, that you have no time limit; "I,_____, have all the time that I need."

Second, affirm that it is safe for you to forgive; "It is safe for me,_____, to forgive _____."

Third, affirm that you find it easy to forgive; "I,_____, am a forgiving person."

Fourth, start on the little things first.

HOW DO I KNOW WHAT TO FORGIVE?

If a thought or memory comes into your head and you feel tension in your body,, and resentful, angry, hurt or sorry for yourself, then there is something or somebody you haven't forgiven.

One very effective way is to take lots of paper, give yourself lots of time and start writing;

"I am angry with_____, because_____."
AND "I am angry with _____, because_____,and_____,and_____."
OR "I feel resentful about _____, and_____,and _____."
OR "I felt hurt when _____."
OR "I hate myself because_____, and when_____."
OR "I feel upset when _____." Etc, etc.

Write down every little thing you can think of including when Jack Smith pushed you off your bike when you were 5 years old.

If you begin to feel overwhelmed with the amount of anger, resentment, and hate you have been carrying around with you for all these years, affirm that its OK to have these feelings and that its OK to transfer the feelings onto paper. Write until you can't think of anything more that you have been upset by.

You may find that merely writing some things done has cleared them from your head and you can now laugh about them. Say "I,_____, forgive _____ for _____", and strike those things of your list.

There is no hurry! This much may be enough for you for days, weeks, or even longer. "Everything I,_____,do, is done at a perfect time for me."

When you are ready, you can use affirmations in the usual way - with or without responses to give up all the pain connected to a certain person or event. "I,_____, forgive _____ for everything." "I,_____, forgive myself for everything."

You may make a commitment to yourself to write your affirmation 70 times per day for 7 days, or you may choose another way. Remember, its your choice and <u>you do not have to forgive</u> - you may instead choose to hold on to the hurt and pain. Just know that its an option open to you.

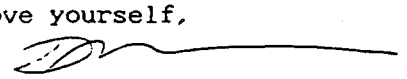
SUMMARY - OR WHERE TO GO FROM HERE!

The intention of this course was to remind you that you have a lot of power. Everything you do, you do by choice at some level, and with the very best of intentions, using the best choices available to you at the time.

Hopefully, participation in the group sessions has allowed you to realize that there are more choices to add to your already adequate repertoire. There is no hurry to include these options. There may be enough material in the handouts, or in what group members have said to think about for months or even years. You will find further material in the form of people, courses, and books, when you are ready for it.

I would like to thank you very much for participating in this programme. I really appreciate it.

Love yourself,



Dale Mercier, 1986.

ASSERTIVENESS

Saying 'No' without feeling guilty

1. I,_____, have the right to have my own feelings, opinions, and beliefs. I also have the right to do what I choose with my own time, assets, money etc.
2. I believe others have the right to make requests of me. If I choose to say 'no' I am not rejecting them, but simply refusing a request.
3. I do not have to make up my mind immediately. Saying 'I'd like to think about it for a few minutes (an hour, a day, a week, or however long I need)' gives me time to explore my own feelings and decide what I really want.
4. If I were to say 'yes' when I really mean 'no' I would be denying my own importance.
5. When I say 'no', I am direct, concise and to the point. No forms of cajoling, begging, compliments etc will effect my decision. However, I am free to change my mind. That is my choice.
6. I don't make excuses for saying 'no' though I may choose to offer reasons if I feel more comfortable doing so. I do not apologize for having my own needs, feelings or opinions.
7. I say 'no' in such a way as to show that I have choice and take personal responsibity for my actions.
8. Saying 'no' to some requests leaves me more time and energy to say 'yes' with enthusiasm.
9. I find it easier and easier to say 'no'.

Making Requests

1. I have needs, wants and preferences that, like other peoples, are valid.
2. I deny my own importance when I do not ask for what I want.
3. I ask directly and specifically for what I want.
4. When others say 'no' to my requests, I realize that they are not rejecting me, but merely saying 'no' to a request.
5. If others say 'yes' to my request, when they really want to say 'no', that is their responsibility and not mine.
6. What others think about me is entirely their business.
7. I find it easier and easier to recognise and ask for what I really want.

Compliments

GIVING: When I give a compliment I do so honestly and directly.
RECIEVING: I allow others to have feelings and opinions, and accept compliments graciously, even if my opinion differs.

Assertive Language

I communicate my personal autonomy, choice and involvement by using 'I' statements such as 'I think', 'I would like to', 'I don't agree', 'I believe', 'I feel', 'I prefer', 'I have decided', 'I won't', 'I like'. I allow others to communicate their autonomy, choice and involvement.

It is clear from my language that I think I am OK and that I also think others are OK.

Change

I have the right to change and grow. Whilst I understand that others may find the changes I make difficult at first, I will not prevent this from doing what seems best for me.

DALE MERCIER, 1986.

Assertive Training: Refusing Requests Using The "Broken Record" Technique

Sitution One

Request 1: Pat I really need to borrow your car again today. I promise nothing will happen like last time. I really need it.
Refusal 1: Um, I'd really rather, um, that you didn't and I think I need it today.

Request 2: Oh come on – I really am desperate. I have a job interview on the other side of town and haven't much time. Please.
Refusal 2: But I do need it myself and last time you were two hours late back.

Request 3: I won't be, honest: You can trust me.
Refusal 3: I know, but.....

Request 4: Then what is it ?
Refusal 4: I do need it later on.

Request 5: What time?
Refusal 5: Um, I'm not sure – maybe about 2p.m.

Request 6: Easy. I'll have it back by then. I'd buy my own if I had as much money as you. You don't want me to miss out on a job because I can't get to the interview, do you?
Refusal 6: No, but....

Request 7: Look I'll have it back and I'll even put some petrol in it. Also pay you back for the last time too. That's fair, isn't it?
Refusal 7: Well, yes, but...

Request 8: Good, thanks.

Situation Two

Request 1: Pat, I really need to borrow your car again today. I promise nothing will happen like last time. I really need it.
Refusal 1: I'm sure you do Jackie but as I told you last time, I've decided not to lend it anymore.

Request 2: Oh come on, I'm desperate. I have a job interview on the other side of town and haven't much time. Please.
Refusal 2: No, I've decided not to lend it anymore.

Request 3: I promise I won't be late like before. You don't need it today, do you?
Refusal 3: I do need it, but anyway, I've decided not to lend it anymore.

Request 4: What time do you need it? I promise I'll have it back.
Refusal 4: You probably would, but I've decided not to lend it anymore.

Request 5: Well, well, OK....

Workable Compromise

Naturally there will be times when you want to comply with a request. Other times a compromise might be the answer, provided you choose to compromise.

1. What would a workable compromise be in the above situation?
2. Under what circumstances might Pat offer such a compromise?

Relationships

Relationships.

You may have decided you want a relationship (eg friend, or lover). Write down all the qualities you would him (or her,) to have. Think carefully! How would you like him to see you?

QUALITIES I AM LOOKING FOR!

QUALITIES I WOULD LIKE HIM TO SEE IN ME!

Now make up some affirmations in the form; "I,_____, deserve to have a relationship with a man who_____(naming each quality), and "I,_____ am a _____ person (naming the personal qualities you have listed eg lovable, amusing etc).

Appendix D

Questionnaires

D.1 General Information Questionnaire

Name: _____

Age: _____ years _____ months

Occupation: _____

N.B. For the following, put a dash for questions not applicable.

1. How old were you when you first:

   (a) felt dissatisfied with your size/weight? _____
   (b) went on a diet? _____
   (c) used laxatives? _____
   (d) used self-induced vomiting? _____
   (e) saw yourself as having a problem to do with eating? _____

2. Did/do other members of your family have eating disorders, or diet? (YES/NO)

   (a) Mother _____
   (b) Father _____
   (c) Sisters _____
   (d) Brothers _____
   (e) Spouse _____
   (f) Children

3. When were the worst times for you concerning this problem? (e.g. adolescence, pregnancy, marriage breakup etc.)?

   _____

   _____

4. Have you tried counselling or other methods of treatment to lose weight or help with your problem (e.g. Weightwatchers, psychologist, hospitalization, drugs etc.)?

   _____

   _____

5. How helpful were these methods? _____

   _____

6. Why do you think the problem may have started initially?

   _____

   _____

7. What is the current effect of the problem on your life now? _____

   _____

TABLE D.1: DSSI Description - Putative Clinical Syndromes

Class 1 - Dysthymic States (DS)		Neurotic States	
State of Anxiety	- sA	Anxiety State	- AS
State of Depression	- sD	Neurotic Depression	- ND
State of Elation	- sE	Hypomania	- HM
Class 2 - Neurotic Symptoms (NS)		Neurotic States	
Conversion symptoms	- CVs	Conversion Hysteria	- CH
Dissociative symptoms	- Ds	Dissociative Hysteria	- DH
Phobic symptoms	- Ps	Phobic Disorder	- Ph
Compulsive symptoms	- CPs	Obsessional Disorder (rituals)	- OD
Ruminative symptoms	- Rs	Obsessional Disorder (ruminations)	- OR
Class 3 - Integrated Delusions (D)		Integrated Psychosis	
delusions of Persecution	- dP	Paranoid Disorder	- Pa
delusions of Grandeur	- dG	Mania	- Ma
delusions of Contrition	- dC	Psychotic Depression	- PD
Class 4 - Delusions of Disintegration (DD)		Disintegrated Psychosis	
delusions of Disintegration	-dD	Schizophrenia	- Sc

D.2 The Delusions-Symptoms-State Inventory (DSSI-R)

There are 84 items - 7 items for each of 12 clinical syndromes. These form 4 hierarchical classes of personal illness each with its constituent groups of clinical syndromes covering neurotic and psychotic diagnosis and ordered by increasing degrees of adverse change in a person. The model predicts that a person with symptoms at any class level will necessarily have symptoms at all the lower class levels. A description of these syndromes appears in Table I. In a study designed to test this model, the ratings of psychiatrists conformed to the hierarchy in 90% of cases. Levels of agreement of scores on the DSSI with the hierarchy model among 480 psychiatric patients was 93.3% (Bedford and Foulds, 1978.)

Scoring: The subject answers each of the items true or false.

If true, she is asked to indicate the extent to which she is distressed by it, e.g., a bit, a lot, unbearably. A score of 0 is given false responses, whilst scores of 1, 2, or 3 indicate degree of distress felt when response is 'true'. A total score is given for each of the 12 sets of items. A total of 4 or more on any of the sets indicates with reasonable confidence that a person 'really has' symptoms within that set.

Private and Confidential

FOULDS AND BEDFORD P.D. INVENTORY AND SCALES

D.S.S.I.(R)

INSTRUCTIONS

This booklet contains descriptions of how you may have felt, thought, or acted *recently*.

After reading each statement you have to put a circle round either 'False' or 'True', depending upon which is the correct answer for you. On the occasions when you have marked 'True' you then have to indicate how much this *upset* you. Do this by putting a circle round the *one* phrase or word which best explains this.

If you had marked 'False' with a circle you would just go on to read the next statement.

Your answers will be regarded as strictly confidential.

EXAMPLES

1. Recently I have been getting frequent headaches.

False (True) If true, this has upset me:-

Unbearably (A lot) A bit

The first example would mean that recently you have been getting frequent headaches which upset you a lot.

2. Recently my concentration has been poor.

False (True) If true, this has upset me:-

(A bit) A lot Unbearably

The second example would mean that recently your concentration has been poor, which upset you a bit.

3. Recently people have been getting on my nerves.

(False) True If true, this has upset me:-

Unbearably A lot A bit

The third example would mean that recently people have *not* been getting on your nerves.

4. Recently I have worried about family troubles.

False (True) If true, this has upset me:-

A bit A lot (Unbearably)

The fourth example would mean that recently you had worried about family troubles, which has upset you unbearably.

If you are not sure what to do please ask *now*. Otherwise begin on the next page.

1. Recently I have been breathless *or* had a pounding of my heart.

False True If true, this has upset me:-

A bit A lot Unbearably

2. Recently I have lost the use of one of my arms *or* legs for a time.

False True If true, this has upset me:-

Unbearably A lot A bit

3. Recently I have felt that an organisation or group has been planning my downfall.

False True If true, how sure are you?

Not very Fairly Certain

4. Recently I have been very excitedly happy for no particular reason.

False True If true, how often?

Nearly always Often Seldom

5. Recently I have been *unnecessarily* careful about carrying out even simple everyday tasks.

False True If true, this has upset me:-

A bit A lot Unbearably

6. Recently I have seen visions of strange things which no one else could see.

False True If true, how sure are you?

Certain Fairly Not very

7. Recently the future has seemed hopeless.

False True If true, how hopeless?

A bit Very Completely

8. Recently I have been afraid of heights.

False True If true, this has upset me:-

Unbearably A lot A bit

9. Recently I have considered myself superior to *everyone*.

False True If true, how sure are you?

Not very Fairly Certain

10. Recently I have had nagging doubts about nearly everything that I have done.

False True If true, this has upset me:-

Unbearably A lot A bit

11. Recently I have harmed people because I am unclean *or* evil.

False True If true, how sure are you?

Not very Fairly Certain

12. Recently I have been sleep-walking.

False True If true, this has upset me:-

Unbearably A lot A bit

13. Recently, for no good reason, I have had feelings of panic.

False True If true, this has upset me:-

Unbearably A lot A bit

14. Recently I lost my sight *or* hearing for a while and then it came back.

False True If true, this has upset me:-

A bit A lot Unbearably

15. Recently there have been people trying to poison me or do me *very great harm*.

False True If true, how sure are you?

Certain Fairly Not very

16. Recently, I just haven't been able to stop laughing and joking with *everyone*.

False True If true, how often?

Seldom Often Nearly always

17. Recently I have been unable to stop myself from counting, *or* tapping things, *or* uttering phrases *quite pointlessly*.

False True If true, this has upset me:-

Unbearably A lot A bit

18. Recently I have felt that I have been interfered with sexually *or* electrically.

False True If true, how sure are you?

Not very Fairly Certain

19. Recently I have lost interest in just about *everything*.

False True If true, how much loss?

Complete A lot A bit

20. Recently I have had a fear of some harmless animal *or* insect.

False True If true, this has upset me:-

A bit A lot Unbearably

21. Recently I have felt that I am a *very much* greater person than most people think.

False True If true, how sure are you?

Certain Fairly Not very

22. Recently I have been afraid of the thought that I might make a physical attack on someone.

False True If true, this has upset me:-

A bit A lot Unbearably

23. Recently people have been talking about me because of my wicked deeds.

False True If true, how sure are you?

Certain Fairly Not very

24. Recently I have lost my memory and forgotten who I was, *or* where I lived.

False True If true, this has upset me:-

A bit A lot Unbearably

PTO

25. Recently I have been so 'worked up' that I couldn't sit still.

False True If true, this has upset me:-

Unbearably A lot A bit

26. Recently I have had pains which *moved about* to different parts of my body.

False True If true, this has upset me:-

A bit A lot Unbearably

27. Recently someone has *deliberately* tried to make me ill.

False True If true, how sure are you?

Fairly Not very Uncertain

28. Recently new ideas and schemes have been *rushing* through my head one after another.

False True If true, how often?

Seldom Often Nearly always

29. Recently I have had to keep on checking things again and again *quite unnecessarily*.

False True If true, this has upset me:-

Unbearably A lot A bit

30. Recently I have wondered whether I am male or female.

False True If true, how puzzled are you?

A bit Very Extremely

31. Recently I have been so depressed that I have thought of doing away with myself.

False True If true, how seriously?

Completely Very Not very

32. Recently I have been afraid of handling some weapon or sharp object.

False True If true, this has upset me:-

A bit A lot Unbearably

33. Recently I have felt that I have been sent to save the world.

False True If true, how sure are you?

Certain Fairly Not very

34. Recently I have had an *unreasonable* fear that I might forget to do something and then something *really awful* might happen.

False True If true, this has upset me:-

A bit A lot Unbearably

35. Recently I have thought that the world is such an evil place that I, and those nearest to me, would be better out of it.

False True If true, how sure are you?

Certain Fairly Not very

36. Recently all my behaviour became like that of a young child for quite some time.

False True If true, this has upset me:-

A bit A lot Unbearably

37. Recently I have had a pain *or* tense feeling in my neck *or* head.

False True If true, this has upset me:-

Unbearably A lot A bit

38. Recently I have often had difficulty in keeping my balance.

False True If true, this has upset me:-

A bit A lot Unbearably

39. Recently people have been secretly plotting to ruin me.

False True If true, how sure are you?

Certain Fairly Not very

40. Recently I have had so much pep and energy that I could hardly stop doing things.

False True If true, how often?

Seldom Often Nearly always

41. Recently I have kept having to wash myself *again and again*.

False True If true, this has upset me:-

Unbearably A lot A bit

42. Recently someone else has been doing the thinking that goes on in my head.

False True If true, how sure are you?

Not very Fairly Certain

43. Recently I have been so miserable that I have had difficulty with my sleep.

False True If true, this has upset me:-

Unbearably A lot A bit

44. Recently I have had an *unreasonable* fear of germs.

False True If true, this has upset me:-

A bit A lot Unbearably

45. Recently I have felt I must tell the whole world of my brilliant ideas.

False True If true, how sure are you?

Certain Fairly Not very

46. Recently I have had nagging fears that someone close to me might be killed or seriously injured.

False True If true, this has upset me:-

A bit A lot Unbearably

47. Recently I have felt that I am condemned *forever*.

False True If true, how sure are you?

Certain Fairly Not very

48. Recently people around me have seemed strange, unfamiliar, or different.

False True If true, are they *really*?

Not really Not sure Really are

PTO

49. Recently I have worried about every little thing.

False True If true, this has upset me:-

Unbearably A lot A bit

50. Recently I have been unable to control my violent shaking.

False True If true, this has upset me:-

A bit A lot Unbearably

51. Recently someone has had evil designs against me.

False True If true, how sure are you?

Certain Fairly Not very

52. Recently I have been absolutely 'on top of the world'.

False True If true, how often?

Seldom Often Nearly always

53. Recently I have felt *compelled* to do things in a certain order, *or* a certain number of times, to guard against something going wrong.

False True If true, this has upset me:-

Unbearably A lot A bit

54. Recently voices have spoken to me when no one was there at all.

False True If true, how sure are you?

Not very Fairly Certain

55. Recently I have been so low in spirits that I have sat for ages doing absolutely nothing.

False True If true, this has upset me:-

Unbearably A lot A bit

56. Recently I have had a fear of enclosed spaces.

False True If true, this has upset me:-

A bit A lot Unbearably

57. Recently I have felt that I have a mission to carry out of great importance to the world.

False True If true, how sure are you?

Certain Fairly Not very

58. Recently nasty thoughts *or* words have kept running through my mind *against my will.*

False True If true, this has upset me:-

A bit A lot Unbearably

59. Recently I have felt that I have committed the unforgivable sin.

False True If true, how sure are you?

Certain Fairly Not very

60. Recently things around me have seemed odd, unfamiliar, or changed.

False True If true, are they really odd or do they just seem so?

Not really Not sure Really are

61. Recently worrying has kept me awake at night.

False True If true, this has upset me:-

Unbearably A lot A bit

62. Recently I have had fits.

False True If true, this has upset me:-

A bit A lot Unbearably

63. Recently I have thought that I was being followed for a special reason.

False True If true, how sure are you?

Certain Fairly Not very

64. Recently I have been so cheerful that I have wanted to decorate myself with *much* brighter, *more* colourful things, than I usually do.

False True If true, how often?

Seldom Often Nearly always

65. Recently I have had to wash things *again and again* to make absolutely certain that they were safe.

False True If true, this has upset me:-

Unbearably A lot A bit

66. Recently I have felt there was a special meaning in one side of my body being different from the other.

False True If true, how sure are you?

Not very Fairly Certain

67. Recently I have been depressed without knowing why.

False True If true, how depressed?

Extremely Very Fairly

68. Recently I have been frightened of going into crowds or social gatherings.

False True If true, this has upset me:-

A bit A lot Unbearably

69. Recently I have thought that I am the richest person in the world.

False True If true, how sure are you?

Certain Fairly Not very

70. Recently I have been worried by the thought that certain things might have been left lying around.

False True If true, this has upset me:-

A bit A lot Unbearably

71. Recently I have felt that I am the vilest, most wicked person alive.

False True If true, how sure are you?

Certain Fairly Not very

72. Recently I have lost consciousness for a few seconds without actually falling.

False True If true, this has upset me:-

A bit A lot Unbearably

PTO

73. Recently I have been so anxious that I couldn't make up my mind about the simplest thing.

False True If true, how anxious?

Extremely Very Fairly

74. Recently I have had burning *or* tingling sensations under my skin which were much worse than 'pins and needles'.

False True If true, this has upset me:-

A bit A lot Unbearably

75. Recently people have been trying to drive me insane.

False True If true, how sure are you?

Certain Fairly Not very

76. Recently things could not have been better in *any* way.

False True If true, how often have you felt that way?

Now and again Often Nearly always

77. Recently I have felt *compelled* to keep on touching things.

False True If true, this has upset me:-

Unbearably A lot A bit

78. Recently my feelings have been taken over by someone.

False True If true, how sure are you?

Not very Fairly Certain

79. Recently I have gone to bed not caring if I never woke up.

False True If true, how serious was this?

Desperately Very Fairly

80. Recently I have been quite unable to bring myself to go out alone.

False True If true, this has upset me:-

A bit A lot Unbearably

81. Recently I have felt that I have special, almost magical, powers.

False True If true, how sure are you?

Certain Fairly Not very

82. Recently I have had persistent feelings of having left something unfinished without knowing what.

False True If true, this has upset me:-

A bit A lot Unbearably

83. Recently I have felt that my insides are all rotten.

False True If true, how sure are you?

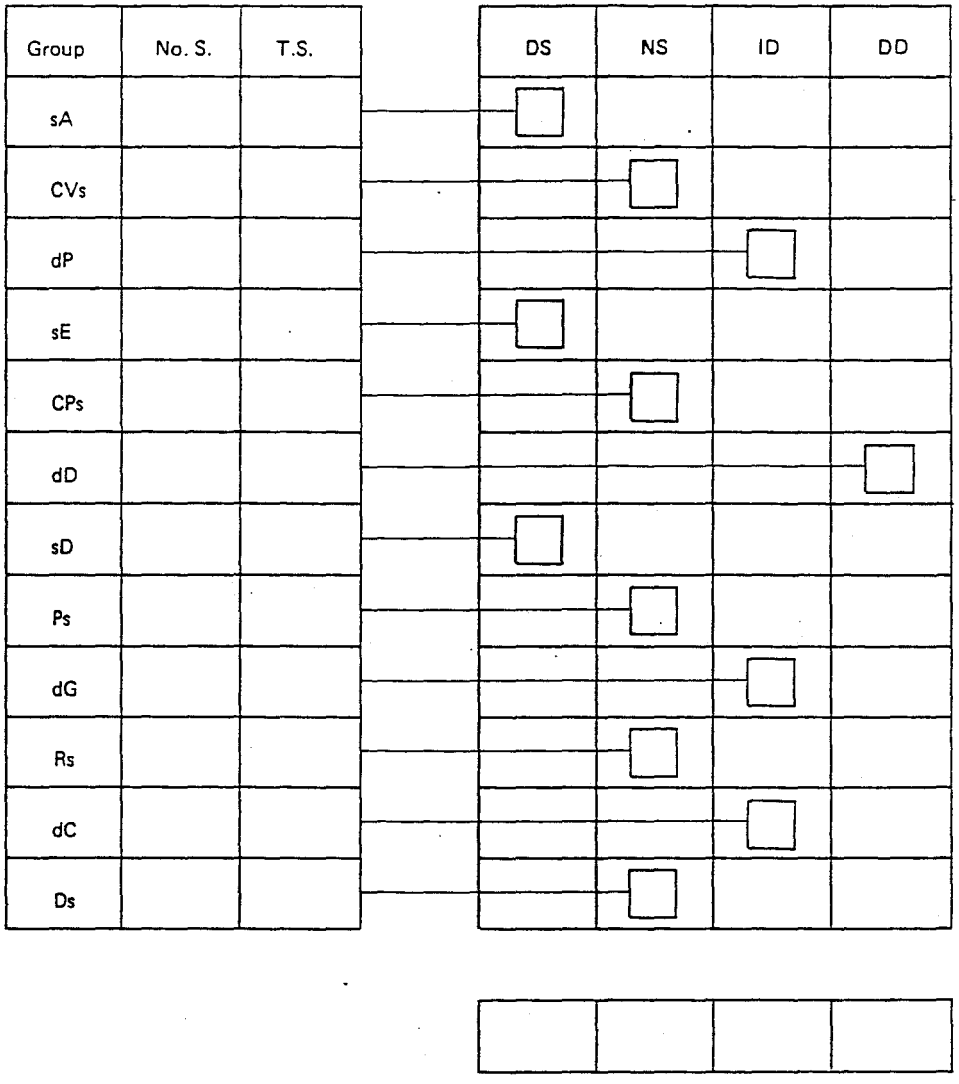
Certain Fairly Not very

84. Recently I have found myself in some place without knowing *why* I was there or *how* I got there.

False True If true, this has upset me:-

A bit A lot Unbearably

Now please check that you have circled 'False' or 'True' for *every* statement; and when 'True' was marked that *one* of the three choices is also circled.



C.N. No. .....

P. Diag. .....

Pers. A. .....

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D.3 Bulit—bulimia

Answer each question on the following pages by filling in the appropriate circles on the computer answer sheet. Please respond to each item as honestly as possible; remember, all of the information you provide will be kept strictly confidential.

1. Do you ever eat uncontrollably to the point of stuffing yourself (i.e. going on eating binges)?
   (a) Once a month or less (or never)
   (b) 2-3 times a month
   (c) Once or twice a week
   (d) 3-6 times a week
   (e) Once a day or more

2. I am satisfied with my eating patterns.
   (a) Agree
   (b) Neutral
   (c) Disagree a little
   (d) Disagree
   (e) Disagree strongly

3. Have you ever kept eating until you thought you'd explode?
   (a) Practically every time I eat
   (b) Very frequently
   (c) Often
   (d) Sometimes
   (e) Seldom or never

4. Would you presently call yourself a "binge eater"?
   (a) Yes, absolutely
   (b) Yes
   (c) Yes, probably
   (d) Yes, possibly
   (e) No, probably not

5. I prefer to eat:
   (a) At home alone
   (b) At home with others
   (c) In a public restaurant
   (d) At a friend's house
   (e) Doesn't matter

6. Do you feel you have control over the amount of food you consume?
   (a) Most or all of the time
   (b) A lot of the time
   (c) Occasionally
   (d) Rarely
   (e) Never

7. I use laxatives or suppositories to help control my weight.
   (a) Once a day or more
   (b) 3-6 times a week
   (c) Once or twice a week
   (d) 2-3 times a month
   (e) Once a month or less (or never)

8. I eat until I feel too tired to continue.
   (a) At least once a day
   (b) 3-6 times a week
   (c) Once or twice a week
   (d) 2-3 times a month
   (e) Once a month or less (or never)

9. How often do you prefer eating ice cream, cokes, milk shakes, or puddings, etc. during a binge?

   (a) Always
   (b) Frequently
   (c) Sometimes
   (d) Seldom or never
   (e) I don't binge

10. How much are you concerned about your eating binges?

   (a) I don't binge
   (b) Bothers me a little
   (c) Moderate concern
   (d) Major concern
   (e) Probably the biggest concern in my life

11. Most people I know would be amazed if they knew how much food I can consume at one sitting.

   (a) Without a doubt
   (b) Very probably
   (c) Probably
   (d) Possibly
   (e) No

12. Do you ever eat to the point of feeling sick?

   (a) Very frequently
   (b) Frequently
   (c) Fairly often
   (d) Occasionally
   (e) Rarely or never

13. I am afraid to eat anything for fear that I won't be able to stop.

   (a) Always
   (b) Almost always
   (c) Frequently
   (d) Sometimes
   (e) Seldom or never

14. I don't like myself after I eat too much.

   (a) Always
   (b) Frequently
   (c) Sometimes
   (d) Seldom or never
   (e) I don't eat too much

15. How often do you intentionally vomit after eating?

   (a) 2 or more times a week
   (b) Once a week
   (c) 2-3 times a month
   (d) Once a month
   (e) Less than once a month (or never)

16. Which of the following describes your feelings after binge eating?

   (a) I don't binge eat
   (b) I feel O.K.
   (c) I feel mildly upset with myself
   (d) I feel quite upset with myself
   (e) I hate myself

17. I eat a lot of food when I'm not even hungry.

(a) Very frequently
(b) Frequently
(c) Occasionally
(d) Sometimes
(e) Seldom or never

18. My eating patterns are different from eating patterns of most people.

(a) Always
(b) Almost always
(c) Frequently
(d) Sometimes
(e) Seldom or never

19. I have tried to lose weight by fasting or going on "crash" diets.

(a) Not in the past year
(b) Once in the past year
(c) 2-3 times in the past year
(d) 4-5 times in the past year
(e) More than 5 times in the past year

20. I feel sad or blue after eating more than I'd planned to eat.

(a) Always
(b) Almost always
(c) Frequently
(d) Sometimes
(e) Seldom, never, or not applicable

21. When engaged in an eating binge, I tend to eat foods that are high in carbohydrates (sweets and starches).

(a) Always
(b) Almost always
(c) Frequently
(d) Sometimes
(e) Seldom, or I don't binge

22. Compared to most people, my ability to control my eating behaviour seems to be:

(a) Great than others' ability
(b) About the same
(c) Less
(d) Much less
(e) I have absolute no control

23. Once of your best friends suddenly suggests that you both eat at a new restaurant buffet that night. Although you'd planned on eating something light at home, you go ahead and eat out, eating quite a lot and feeling uncomfortably full. How would you feel about yourself on the ride home?

(a) Fine, glad I'd tried that new restaurant
(b) A little regretful that I'd eaten so much
(c) Somewhat disappointed in myself
(d) Upset with myself
(e) Totally disgusted with myself

24. I would presently label myself a "compulsive eater" (one who engages in episodes of uncontrolled eating).

(a) Absolutely
(b) Yes
(c) Yes, probably
(d) Yes, possibly
(e) No, probably not

25. What is the most weight you've ever lost in one month?

(a) Over 20 pounds
(b) 12-20 pounds
(c) 8-11 pounds
(d) 4-7 pounds
(e) Less than 4 pounds

26. If I eat too much at night I feel depressed the next morning.

(a) Always
(b) Frequently
(c) Sometimes
(d) Seldom or never
(e) I don't eat too much at night

27. Do you believe that it is easier for you to vomit than it is for most people?

(a) Yes, it's no problem at all for me
(b) Yes, it's easier
(c) Yes, it's a little easier
(d) About the same
(e) No, it's less easy

28. I feel that food controls my life.

(a) Always
(b) Almost always
(c) Frequently
(d) Sometimes
(e) Seldom or never

29. I feel depressed immediately after I eat too much.

(a) Always
(b) Frequently
(c) Sometimes
(d) Seldom or never
(e) I don't eat too much

30. How ofen do you vomit after eating in order to lose weight?

(a) Less than once a month (or never)
(b) Once a month
(c) 2-3 times a month
(d) Once a week
(e) 2 or more times a week

31. When consuming a large quantity of food, at what rate of speed do you usually eat?

(a) More rapidly than most people have ever eaten in their lives
(b) A lot more rapidly than most people
(c) A little more rapidly than most people
(d) About the same rate as most people
(e) More slowly than most people (or not applicable)

32. What is the most weight you've ever gained in one month?

(a) Over 20 pounds
(b) 12-20 pounds
(c) 8-11 pounds
(d) 4-7 pounds
(e) Less than 4 pounds

33. Females only. My last menstrual period was:

(a) Within the past month
(b) Within the past 2 months
(c) Within the past 4 months
(d) Within the past 6 months
(e) Not within the past 6 months

34. I use diuretics (water pills) to help control my weight.

(a) Once a day or more
(b) 3-6 times a week
(c) Once or twice a week
(d) 2-3 times a month
(e) Once a month or less (or never)

35. How do you think your appetite compares with that of most people you know?

(a) Many times larger than most
(b) Much larger
(c) A little larger
(d) About the same
(e) Smaller than most

36. Females only. My menstrual cycles occur once a month:

(a) Always
(b) Usually
(c) Sometimes
(d) Seldom
(e) Never

D.4 Affectometer 2—wellbeing

Affectometer 2 is a questionnaire for reporting how often you have certain general feelings which are related to your emotional satisfaction and life fulfilment.

There is no point in filling out this questionnaire unless you describe your own honest feelings as best you can.

The items are either sentences or adjectives which describe different feelings about yourself and your life. For each item, please check how often you have had that feeling over:

(time period) _____

If the time period is not filled in the blank space above, you should be told what to write in there by the person administering the questionnaire. If no instructions are given, write in "The past few weeks", and use that as your time period.

You have five choices for how often you have felt each feeling.

These are:

not at all

occasionally

some of the time

often

all of the time

Please make a small checkmark (✓) in the column which shows how often the item applies to you. You may wish that you could choose a phrase which is in-between one of the choices given, but if you choose the one which comes closest to your experiences, your results will still be very accurate. You do not need to spend a long time on the items.

Your name is

_____ needed for filing

_____ not needed for filing

Your address is

_____ needed for filing

_____ not needed for filing

Name (if needed) _____

Address (if needed) _____

_____

_____

Affectometer 2 Form A-1

Please copy the time period given in the Instructions here:

(time period) _____

Over this time period I have had the feeling described by (each) item ...
(how often -- check one column only):

Not at all
Occasionally
Some of the time
Often
All the time

Feeling	Not at all	Occa-sion-ally	Some of the time	Often	All the time	For Office Use (-)	For Office Use (+)
1. My life is on the right track							☐
2. I seem to be left alone when I don't want to be						☐	
3. I feel I can do whatever I want to							☐
4. I think clearly and creatively							☐
5. I feel like a failure						☐	
6. Nothing seems very much fun any more						☐	
7. I like myself							☐
8. I can't be bothered doing anything						☐	
9. I feel close to people around me.							☐
10. I feel as though the best years of my life are over						☐	
	0	1	2	3	4		

Affectometer 2 Form A-2

Please copy the time period given in the Instructions here:

(time period) _____

Over this time period I have had the feeling described by (each) item ...
(how often -- check one column only):

Not at all
Occasionally
Some of the time
Often
All the time

Feeling	Not at all	Occa-sion-ally	Some of the time	Often	All the time	For Office Use (-)	For Office Use (+)
1. My future looks good.							☐
2. I have lost interest in other people and don't care about them.						☐	
3. I have energy to spare.							☐
4. I smile and laugh a lot.							☐
5. I wish I could change some parts of my life.						☐	
6. My thoughts go around in useless circles.						☐	
7. I can handle any problems that come up.							☐
8. My life seems stuck in a rut.						☐	
9. I feel loved and trusted.							☐
10. I feel there must be something wrong with me.						☐	
	0	1	2	3	4		

Affectometer 2 Form B-1

Please copy the time period given in the Instructions here:

(time period) _____

Over this time period I have had the feeling described by (each) item ...
(how often -- check one column only):

Not at all
Occasionally
Some of the time
Often
All the time

Feeling	Not at all	Occa-sion-ally	Some of the time	Often	All the time	For Office Use (-)	For Office Use (+)
1. satisfied							☐
2. lonely						☐	
3. free-and-easy							☐
4. clear-headed							☐
5. helpless						☐	
6. impatient						☐	
7. useful							☐
8. depressed						☐	
9. loving							☐
10. hopeless						☐	
	0	1	2	3	4		

Affectometer 2 Form B-2

Please copy the time period given in the Instructions here:

(time period) _____

Over this time period I have had the feeling described by (each) item ...
(how often -- check one column only):

Not at all
Occasionally
Some of the time
Often
All the time

Feeling	Not at all	Occa-sion-ally	Some of the time	Often	All the time	For Office Use (-)	For Office Use (+)
1. optimistic							☐
2. withdrawn						☐	
3. enthusiastic							☐
4. good-natured							☐
5. discontented						☐	
6. confused						☐	
7. confident							☐
8. tense						☐	
9. understood							☐
10. insignificant						☐	
	0	1	2	3	4		

D.5 STAI—anxiety

SELF-EVALUATION QUESTIONNAIRE

Developed by Charles D. Spielberger
in collaboration with
R. L. Gorsuch, R. Lushene, P. R. Vagg, and G. A. Jacobs

STAI Form Y-1

Name _____ _____ Date _____ S ____

Age _____ Sex: M ____ F ____ T ____

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel *right* now, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	NOT AT ALL	SOMEWHAT	MODERATELY SO	VERY MUCH SO
1. I feel calm	①	②	③	④
2. I feel secure	①	②	③	④
3. I am tense	①	②	③	④
4. I feel strained	①	②	③	④
5. I feel at ease	①	②	③	④
6. I feel upset	①	②	③	④
7. I am presently worrying over possible misfortunes	①	②	③	④
8. I feel satisfied	①	②	③	④
9. I feel frightened	①	②	③	④
10. I feel comfortable	①	②	③	④
11. I feel self-confident	①	②	③	④
12. I feel nervous	①	②	③	④
13. I am jittery	①	②	③	④
14. I feel indecisive	①	②	③	④
15. I am relaxed	①	②	③	④
16. I feel content	①	②	③	④
17. I am worried	①	②	③	④
18. I feel confused	①	②	③	④
19. I feel steady	①	②	③	④
20. I feel pleasant	①	②	③	④

Consulting Psychologists Press
577 College Avenue, Palo Alto, California 94306

SELF-EVALUATION QUESTIONNAIRE

STAI Form Y-2

Name _____ Date _____

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you *generally* feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

	ALMOST NEVER	SOMETIMES	OFTEN	ALMOST ALWAYS
21. I feel pleasant	①	②	③	④
22. I feel nervous and restless	①	②	③	④
23. I feel satisfied with myself	①	②	③	④
24. I wish I could be as happy as others seem to be	①	②	③	④
25. I feel like a failure	①	②	③	④
26. I feel rested	①	②	③	④
27. I am "calm, cool, and collected"	①	②	③	④
28. I feel that difficulties are piling up so that I cannot overcome them	①	②	③	④
29. I worry too much over something that really doesn't matter	①	②	③	④
30. I am happy	①	②	③	④
31. I have disturbing thoughts	①	②	③	④
32. I lack self-confidence	①	②	③	④
33. I feel secure	①	②	③	④
34. I make decisions easily	①	②	③	④
35. I feel inadequate	①	②	③	④
36. I am content	①	②	③	④
37. Some unimportant thought runs through my mind and bothers me	①	②	③	④
38. I take disappointments so keenly that I can't put them out of my mind	①	②	③	④
39. I am a steady person	①	②	③	④
40. I get in a state of tension or turmoil as I think over my recent concerns and interests	①	②	③	④

D.6 Beck Depression Inventory (shortened form)—depression

INSTRUCTIONS: This is a questionnaire. On the questionnaire are groups of statements. Please read the entire group of statements in each category. Then pick out the one statement in that group which best describes the way you feel today, that is, RIGHT NOW! Circle the number beside the statement you have chosen. If several statements in the group seem to apply equally well, circle each one.

BE SURE TO READ ALL THE STATEMENTS IN EACH GROUP BEFORE MAKING YOUR CHOICE

A.
3 I am so sad or unhappy that I can't stand it.
2 I am blue or sad all the time and I can't snap out of it.
1 I feel sad or blue.
0 I do not feel sad.

B.
3 I feel that the future is hopeless and that things cannot improve.
2 I feel I have nothing to look forward to.
1 I feel discouraged about the future.
0 I am not particularly pessimistic or discouraged about the future.

C.
3 I feel I am a complete failure as a person (parent, husband, wife.)
2 As I look back on my life, all I can see is a lot of failures.
1 I feel I have failed more than the average person.
0 I do not feel like a failure.

D.
3 I am dissatisfied with everything.
2 I don't get satisfaction out of anything any more.
1 I don't enjoy things the way I used to.
0 I am not particularly dissatisfied.

E.
3 I feel as though I am very bad or worthless.
2 I feel quite guilty.
1 I feel bad or unworthy a good part of the time.
0 I don't feel particularly guilty.

F.
3 I hate myself.
2 I am disgusted with myself.
1 I am disappointed in myself.
0 I don't feel disappointed in myself.

G.

3 I would kill myself if I had the chance.

2 I have definite plans about committing suicide.

1 I feel I would be better off dead.

0 I don't have any thoughts of harming myself.

E.

3 I have lost all of my interest in other people.

2 I have lost most of my interest in other people and have little feeling for them.

1 I am less interested in other people than I used to be.

0 I have not lost interest in other people.

I.

3 I can't make any decisions at all any more.

2 I have great difficulty in making decisions.

1 I try to put off making decisions.

0 I make decisions about as well as ever.

J.

3 I feel that I am ugly or repulsive-looking.

2 I feel that there are permanent changes in my appearance and they make me look unattractive.

1 I am worried that I am looking old or unattractive.

0 I don't feel that I look any worse than I used to.

K.

3 I can't do any work at all.

2 I have to push myself very hard to do anything.

1 It takes extra effort to get started in doing something.

0 I can work about as well as before.

L.

3 I get too tired to do anything.

2 I get tired from doing anything.

1 I get tired more easily than I used to.

0 I don't get any more tired than usual.

M.

3 I have no appetite at all any more.

2 My appetite is much worse now.

1 My appetite is not as good as it used to be.

0 My appetite is no worse than usual.

SCORE =

D.7 Rosenberg's Self-esteem Inventory

1. I feel that I'm a person of worth, at least on an equal plane with other.
   1. _____ strongly agree
   2. _____ Agree
   3. _____ Disagree
   4. _____ Strongly disagree
2. I feel that I have a number of good qualities.
   1. _____ Strongly agree
   2. _____ Agree
   3. _____ Disagree
   4. _____ Strongly disagree
3. All in all, I am inclined to feel that I am a failure.
   1. _____ Strongly agree
   2. _____ Agree
   3. _____ Disagree
   4. _____ Strongly disagree
4. I am able to do things as well as most other people.
   1. _____ Strongly agree
   2. _____ Agree
   3. _____ Disagree
   4. _____ Strongly disagree
5. I feel I do not have much to be proud of.
   1. _____ Strongly agree
   2. _____ Agree
   3. _____ Disagree
   4. _____ Strongly disagree

6. I take a positive attitude toward myself.

   1. _____ Strongly agree
   2. _____ Agree
   3. _____ Disagree
   4. _____ Strongly disagree

7. On the whole, I am satisfied with myself.

   1. _____ Strongly agree
   2. _____ Agree
   3. _____ Disagree
   4. _____ Strongly disagree

8. I wish I could have more respect for myself.

   1. _____ Strongly agree
   2. _____ Agree
   3. _____ Disagree
   4. _____ Strongly disagree

9. I certainly feel useless at times.

   1 _____ Strongly agree
   2 _____ Agree
   3 _____ Disagree
   4 _____ Strongly disagree

10. At times I think I am no good at all.

   1 _____ Strongly agree
   2 _____ Agree
   3 _____ Disagree
   4 _____ Strongly disagree

D.8 Gambrill and Ritchie's Assertiveness Questionnaire

Many people experience difficulty in handling interpersonal situations requiring them to assert themselves in some way, for example, turning down a request, asking a favour, giving someone a compliment, expressing disapproval or approval, etc. Please indicate your degree of discomfort or anxiety in the space provided before each situation listed below. Use the following scale to indicate degree of discomfort.

1 = none 2 = a little 3 = a fair amount 4 = much 5 = very much

Then go over the list a second time and indicate after each item the probability or likelihood of your displaying the behaviour as if you were actually in the situation. For example, if you rarely apologize when you are at fault, you would mark a "4" after that item. Use the following scale to indicate likelihood or probability.

1 = always do it 2 = always do it 3 = do it about half the time
4 = rarely do it 5 = never do it

*Note. It is important to cover your discomfort ratings (those in front of the items) while filling in response probability. Please place a piece of paper over your discomfort ratings whilst answering the right hand side.

Degree of discomfort	Situation	Response probability
_____	1. Turn down a request to borrow your car	_____
_____	2. Compliment a friend	_____
_____	3. Ask a favour of someone	_____
_____	4. Resist sales pressure	_____
_____	5. Apologize when you are at fault	_____
_____	6. Turn down a request for a meeting or date	_____
_____	7. Admit fear and request consideration	_____
_____	8. Tell a person you are intimately involved with them when he/she says or does something that bothers you	_____
_____	9. Ask for a raise	_____
_____	10. Admit ignorance in some area	_____
_____	11. Turn down a request to borrow money	_____
_____	12. Ask personal questions	_____
_____	13. Turn off a talkative friend	_____
_____	14. Ask for constructive criticism	_____
_____	15. Initiate a conversation with a stranger	_____
_____	16. Compliment a person you are romantically involved with or interested in	_____
_____	17. Request a meeting or a date with a person	_____
_____	18. Your initial request for a meeting is turned down and you ask the person again at a later time.	_____

ASSERTIVENESS

Degree of discomfort		Situation	Response probability
_____	19.	Admit confusion about a point under discussion and ask for clarification	_____
_____	20.	Apply for a job	_____
_____	21.	Ask whether you have offended someone	_____
_____	22.	Tell someone that you like them	_____
_____	23.	Request expected service when such is not forthcoming e.g. in a restaurant	_____
_____	24.	Discuss openly with the person his/her criticism of your behaviour	_____
_____	25.	Return defective items, e.g. store or restaurant	_____
_____	26.	Express an opinion that differs from that of the person you are talking to.	_____
_____	27.	Resist sexual overtures when you are not interested	_____
_____	28.	Tell the person when you feel he/she has done something that is unfair to you	_____
_____	29.	Accept a date	_____
_____	30.	Tell someone good news about yourself	_____
_____	31.	Resist pressure to drink	_____
_____	32.	Resist a significant person's unfair demand	_____
_____	33.	Quit a job	_____
_____	34.	Resist pressure to "turn on"	_____
_____	35.	Discuss openly with the person his/her criticism of your work	_____
_____	36.	Request the return of borrowed items	_____
_____	37.	Receive compliments	_____
_____	38.	Continue to converse with someone who disagrees with you	_____
_____	39.	Tell afriend or someone with whom you work when he/she says or does something that bothers you	_____
_____	40.	Ask a person who is annoying you in a public situation to stop.	_____

Lastly, please indicate the situations you would like to handle more assertively by placing a circle around the item number.

D.9 Evaluation Questionnaire 1

Your responses to the following questionnaire will hopefully help me to improve future groups. I would appreciate your honesty. Please circle the appropriate numbers, or the letter 'X' if you haven't tried something.

	No value	moderately valuable			extremely valuable	haven't tried this
1. Enjoyment of group	1	2	3	4	5	X
2. Usefulness of individual sessions prior to group	1	2	3	4	5	X
3. Feedback from other group members	1	2	3	4	5	X
4. Feedback from group leader	1	2	3	4	5	X
5. Usefulness of -						
(a) handouts	1	2	3	4	5	X
(b) sharing circle at beginning of session	1	2	3	4	5	X
(c) hearing others problems/ progress	1	2	3	4	5	X
(d) saying 'I choose ...'	1	2	3	4	5	X
(e) changing 'I should ...' into 'I choose ...'	1	2	3	4	5	X
(f) reinterpreting negative self-talk	1	2	3	4	5	X
(g) Playing the 'as if game' (i.e. acting as if something were already true)	1	2	3	4	5	X
(h) Power chart - i.e. things about your parents with polar opposites and how you carry them out	1	2	3	4	5	X
(i) Discussion re dieting/social pressures of women etc.	1	2	3	5	5	
(j) Assertiveness - e.g. 'broken record' technique	1	2	3	4	5	X
(k) Writing down anger	1	2	3	4	5	X
(l) affirmations	1	2	3	4	5	X
(m) discussion on guilt	1	2	3	4	5	X
(n) discussion on fear	1	2	3	4	5	X

	No value		moderately valuable		extremely valuable	haven't tried this
(o) discussion on forgiveness	1	2	3	4	5	X
(p) discussion on anger	1	2	3	4	5	X
(q) individual session during last week	1	2	3	4	5	X
(r) keeping a diary	1	2	3	4	5	X
(s) mental imagery exercises	1	2	3	4	5	X

6. (i) How effective has this group been to you (give a number from 0 - 10, where 0 means 'useless' and 10 means 'absolutely effective'.

Rating: _____

(ii) How much have you changed or expect to change in the future as a result of participating. (Give a rating of 0 - 10, with 0 meaning 'no change whatsoever', and 10 meaning 'immense change'.)

Rating: _____

(iii) Would you recommend participation in this group to another person who has food-related problems? (Give a rating of 0 - 10, with 0 meaning 'certainly not', and 10 meaning 'most definitely').

Rating: _____

7. In what ways were this course particularly important, meaningful, or useful to you?

_____

_____

_____

_____

_____

_____

8. In what ways would you suggest it could be improved for others in the future?

_____

_____

_____

_____

_____

_____

D.10 Evaluation Questionnaire 2

It is now 30 months since your participation in the course. Your response to the following questions will hopefully help me to improve future groups. I would appreciate your honesty. Please circle the appropriate numbers, or the letter 'X' if you haven't tried something, or can't remember having done so, or don't know how useful it has been.

	No value	moderately valuable			extremely valuable	haven't tried this
1. Enjoyment of group	1	2	3	4	5	X
2. Usefulness of individual sessions prior to group	1	2	3	4	5	X
3. Feedback from other group members	1	2	3	4	5	X
4. Feedback from group leader	1	2	3	4	5	X
5. Usefulness of -						
(a) handouts	1	2	3	4	5	X
(b) sharing circle at beginnign of session	1	2	3	4	5	X
(c) hearing others problems/ progress	1	2	3	4	5	X
(d) saying 'I choose ...'	1	2	3	4	5	X
(e) changing 'I should ...' into 'I choose ...'	1	2	3	4	5	X
(f) reinterpreting negative self-talk	1	2	3	4	5	X
(g) discussion re dieting/ social pressures of women etc.	1	2	3	4	5	X
(h) assertiveness - e.g. 'broken record' technique	1	2	3	4	5	X
(i) writing down anger	1	2	3	4	5	X
(j) affirmations	1	2	3	4	5	X
(k) discussion on guilt	1	2	3	4	5	X
(l) discussion on fear	1	2	3	4	5	X
(m) discussion on						

		No value	moderately valuable			extremely valuable	haven't tried this
(m)	discussion on forgiveness	1	2	3	4	5	X
(n)	discussion on anger	1	2	3	4	5	X
(o)	individual session during last week	1	2	3	4	5	X
(p)	keeping a diary	1	2	3	4	5	X

6. (i) How effective has this group been to you (give a number from 0 - 10, where 0 means 'useless' and 10 means 'absolutely effective'.

Rating: _____

(ii) How much have you changed or expect to change in the future as a result of participating. (Give a rating of 0 - 10, with 0 meaning 'no change whatsoever' and 10 meaning 'immense change'.)

Rating: _____

(iii) Would you recommend participation in this group to another person who has food-related problems? (Give a rating of 0 - 10, with 0 meaning 'certainly not',. and 10 meaning 'most definitely').

Rating: _____

7. In what ways were this course particularly important, meaningful, or useful to you?

_____

_____

_____

_____

_____

_____

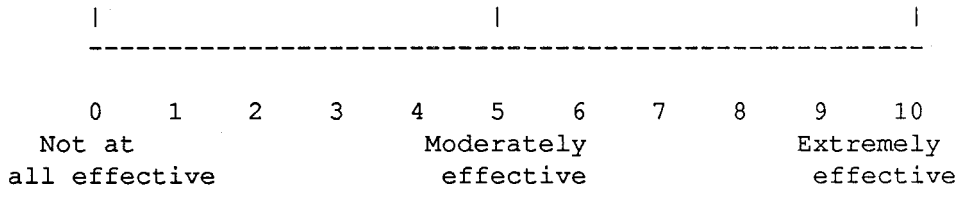
_____

8. In what ways would you suggest it could be improved for others in the future?

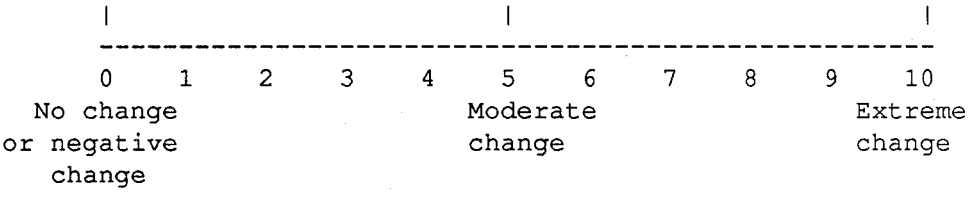
9. Has your life, or lifestyle, changed at all since the course e.g. job change, marriage, shifting house etc.? To what extent do you think this change was a result of group participation?

D.11 Questionnaire re Expectations

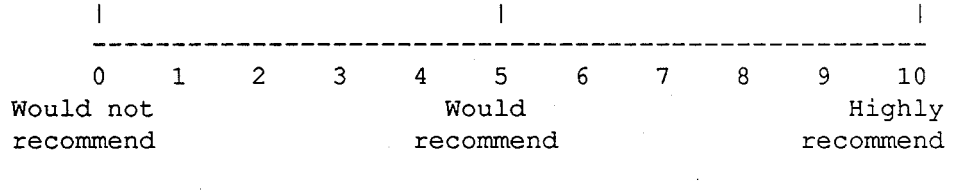
1. On the scale, indicate how effective you think this course is. (Circle a number).



2. Indicate how much you expect to change as a result of it.



3. Indicate how confident you would be to recommend it to friends with eating problems.



D.12 Eidetic Parents Test: Summary of EPT Images

(a) Parents somewhere in the house
(b) L-R position of parents in front
(c) Parents separated or united as a couple
(d) Active-passive relationship between the parents
(e) Which parent runs faster
(f) Pattern and purpose of parental running
(g) Freedom of parental limbs while running
(h) Brilliance of parental eyes
(i) Object orientation of parental eyes
(j) Parental eyes - feelings they give, story they tell
(k) Loudness of parental voices
(l) Degree of meaningfulness in parental voices
(m) Parental voices - feelings they give, story they tell
(n) Degree of hearing by parental ears
(o) Degree of understanding by parental ears
(p) Parents sniffing the house atmosphere
(q) Personal warmth imparted by parental bodies
(r) Feelings of acceptance or rejection in parental skin
(s) Appearance of health in parental skin
(t) Extension of parental arms while giving
(u) Extension of arms while receiving from parents
(v) Strength of parental hand grasp
(w) Manner of parents swallowing food
(x) Manner of parents drinking fluid
(y) Pressure of parental jaws while chewing
(z) Temperature and appearance of parental brains
() Efficacy or inefficiency of parental brain
() Beating of parental hearts
() Appearance of parental intestines
() Temperature and appearance of parental genitals

EIDETIC PARENT'S TEST

Scoring Sheet

Ep.1. Parents somewhere in the house.

Picture your parents in the house where you lived most of the time with them, the house which gives you the feeling of a home. - Where do you see them. - What are they doing? - How do you feel when you see the images? - Are there any memories connected with this picture?

Father: 1. kitchen 2. lounge/living room. 3. elsewhere ____

Mother: 1. kitchen 2. lounge/living room. 3. elsewhere ____

Same room: Yes / No Communicating: Yes / No

Atmosphere?

+ve 1 2 3 4 5 -ve

Father doing?

1 2 3 4 5

Mother doing?

1 2 3 4 5

Memories:

+ve 1 2 3 4 5 -ve

Comments:

Comments: _____

_____

_____

_____

1. Feelings as look at image? _____

_____

+ve 1 2 3 4 5 -ve

2. Physical sensations? _____

_____

none 0 1 2 intense

3. Pleasant / neutral / unpleasant

4. Clarity: clear / fuzzy / no image

5. Completion : father absent/mother absent/both absent

6. Content Psychpathology
   Cause : Father / mother / both

7. Interpetive Psychopathology
   Direction: Father / mother / both

Ex.2 Left-right position of parents in front.

Instructions:

Now, set aside this picture of the house and see your parents standing directly in front of you. - Tell me, as you look at them, who is standing on your left and who is standing on your right? - Now, try to switch their positions. - Do you experience any difficulty or discomfort when you do this? Try to switch their positions again. - Do you again feel any difficulty? Do you feel that these images are independent of your control?

Father left / Father right

Switch: easy / difficult / impossible

Switch again: easy / difficult / impossible

Images independent: Yes / No

Ex.3 The parents separated or united as a couple.

Instructions:

As you see your parents standing in front of you, do they appear separated or united as a couple? - Describe the character of the space each occupies. Do the spaces differ in temperature and illumination?

Together / apart

United / not united

Father:	Foreground		1	2	3		Background
Father:	Light	1	2	3	4	5	dark
	Warm	1	2	3	4	5	cold
Mother:	Light	1	2	3	4	5	dark
	Wqrm	1	2	3	4	5	cold

Ex.4 Active-passive relationship between the parents.

Instruction:

As you see them standing in front of you, which parent seems to be more active and aggressive in the picture? Is he/she extremely active, very active, or just active? - How is the other parent in comparison? Is he/she extremely passive, very passive, or just passive?

More active? Father /mother/ same

Father:	Extremely active	1	2	3	4	5	6	7	extremely passive
Mother	Extremely active	1	2	3	4	5	6	7	extremely passive

Ex.5 Which parent runs faster.

Instruction:

Now set aside this image and picture your parents running in an open countryside. - Are they both running? - Who seems to be running faster? - Is he/she running extremely fast, very fast, or just fast? - How is the other parent running: extremely slow, very slow, or just slow?

Father running : Yes / No

Mother running : Yes / No

Together : Yes / No

Faster : Father / Mother / same

Father:	extremely fast	1	2	3	4	5	6	7	very slow
Mother:	extremely fast	1	2	3	4	5	6	7	very slow

Ep.6 Pattern and purpose of parental running.

Instructions:

Continue watching your parents running in the open countryside. - Now pay attention to the way in which they run. - Describe how each parent is running, the style and pattern of his running. - What seems to be the purpose in their running? - Why are they running?

Ahead: Father / mother

Style: Father. easy 1 2 3 4 5 difficult

Mother, easy 1 2 3 4 5 difficult

Purpose: Joint purpose, Yes / No

Father: pleasure / no purpose / getting away / catching up / other / don't know

Mother: pleasure / no purpose / getting away / catching up / other / don't know

Ep.7 Freedom of parental limbs while running.

Instructions:

As you see your parents running, do their limbs appear stiff or relaxed? - Whose limbs appear more stiff and whose limbs appear more relaxed?

Limbs. Father: relaxed 1 2 3 4 5 stiff

Mother: relaxed 1 2 3 4 5 stiff

More relaxed: Father / mother / same

Ep.8 Brilliance of parental eyes.

Instructions:

Now set aside this picture and see your parents standing directly in front of you again. - Look at their eyes. (Do not recollect their real eyes.) - Whose eyes are more brilliant? - Are they extremely brilliant, very brilliant, or just brilliant? - How do the other parent's eyes appear?

Father: extremely brilliant / very brilliant / brilliant / dull / very dull / missing

Mother: extremely brilliant/ very brilliant / brilliant / dull / very dull / missing

Ep.9 Object orientation of parental eyes.

Instructions:

Now set aside this image and look at me. - As I look at objects, my eyes focus on one object and then another. Now, I am staring into space and my eyes focus on nothing. - Now see your parents' eyes in the image again. - Whose eyes focus on objects more easily? - Are the eyes extremely object oriented, very object oriented, or just object oriented? - How are the other parent's eyes?

Whose eyes focus more easily: Father / mother / same

Father: extremely object oriented / very /

normal / space / missing

Mother: extremely object oriented / very /

normal / space / missing

Ex10 Parental eyes - feelings they give, story they tell.

Instruction:

Continue concentrating on your parents' eyes in the picture. - Do they give you any feeling or tell you any story?

Ex.11 Loudness of parental voices.

Instruction:

Now set aside this picture and see that you are hearing your parents' voices. - Whose voice sounds louder to you? - Is it extremely loud, very loud, or just loud? - How does the other parent's voice sound to you?

Voice louder: Father / mother / same

Father:	extremely loud	1	2	3	4	5	6	7	extremely soft
Mother:	extremely loud	1	2	3	4	5	6	7	extremely soft

Ep.12 Degree of meaningfulness in parental voices.

Instruction:

Now hear your parents' voices again. - Do the voices seem meaningful, or are they merely patterns of sound in the air? Whose voice carried more meaning? - Is it extremely meaningful? - Is it extremely meaningful, very meaningful or just meaningful? - How does the other parent's voice sound to you?

More meaning: Father / mother /same / n either

Father: Extremely meaningful / very meaningful /

meaningful / meaningless / can't tell

Mother: Extremely meaningful / very meaningful /

meaningful / meaningless / can't tell

Ep.13 Parental voices - feelings they give, story they tell.

Instruction:

Continue listening to your parents' voices. - Do they give you any feeling or tell you any story?

Ep.14 Degree of hearing by parental ears.

Instruction:

Now see yourself talking to both your parents - Who seems to hear you better or has good ears for you? - Does he/she hear you extremely well, or just well? - Describe how the other parent hears you.

Hears better: Father / mother / same / neither

Father: extremely well / very well / well /

not very well / not at all

Mother: extremely well / very well / well /

not very well / not at all

Ep 15 Degree of understanding by parental ears.

Instruction:

As you talk to your parents in the image, do they seem to understand you? - Who seems to understand you better? - Does he/she understand you extremely well, very well, or just well? - Describe how much the other parent understands you.

Father: extremely well / very well / well /

not well / not at all

Mother: extremely well / very well / well /

not well / not at all

Ep 16 Parents sniffing the house atmosphere.

Instruction:

Now set aside this image and look at me. I am sniffing the air here in this room, and you can tell by my facial expression whether I like the air or not. Now see your parents sniffing the air in the house in the same way. - Do they appear to like or dislike the house atmosphere?

Father: likes very much / likes / dislikes

Mother: likes very much / likes / dislikes

Ep 17 Personal warmth imparted by parental bodies.

Instruction:

Now see your parents standing directly in front of you again. - Do you get a feeling of personal warmth from their bodies? - Whose body gives you a better feeling of personal warmth? - What kind of feeling does the other parent's body give?

Better feeling: Father / mother / same / neither

Father:

+ve 1 2 3 4 5 -ve

Mother:

+ve 1 2 3 4 5 -ve

Ep 18 Feeling of acceptance or rejection in parental skin.

Instruction:

Now look at your parents' skin and concentrate on it for a while. Does it seem to accept you or reject you? - Describe how you feel when you look at their skin.

Accepts more: Father / mother / same / neither

Father: accept / reject

Mother : accept / reject

Ep 19 Appearance of health in parental skin.

Instruction:

Continue looking at your parents' skin. - Does it appear healthy or unhealthy? - Whose skin appears healthier?

Healther: Father / mother / same / neither

Father:	very healthy	1	2	3	4	5	unhealthy
Mother:	very healthy	1	2	3	4	5	unhealthy

Ep 20 Extension of parental arms while giving.

Instruction:

Now picture your parents giving you something. - Which parent extends the hand more completely for giving? - Show me how your mother extends her arms when she gives. - How does your father extend his arms when he gives?

Extends more: Father / mother / same / neither

Father: fully extended / partially / not extended

Mother: fully extended / partially / not extended

Ep 21 Extension of arms while receiving from parents.

Instruction:

Now picture yourself taking something from your parents.
- To whom do you extend your arms completely?

To whom extend: Father / mother / same / neither

To Father: fully / partially / not extended

To Mother: fully / partially / not extended

Ep 22 Strength of parental hand grasp.

Instruction:

Now see that your parents are holding something in their hands. - Tell me which parent grasps more firmly.
- How is the grasp of the other parent?

More firmly: Father / mother / same / neither

Father: Very firmly 1 2 3 4 5 not able

Mother: Very firmly 1 2 3 4 5 not able

Ep 23 Manner of parents swallowing food.

Instruction:

Now see your parents eating. - Do they swallow easily? - Who swallows with more ease?

More ease: Father / Mother / same / neither

Father: voraciously 1 2 3 4 5 can't swallow

Mother: voraciously 1 2 3 4 5 can't swallow

Ep 24 Manner of parents drinking fluid.

Instruction:

Now see your parents drinking fluid. - Who drinks faster?

Faster: Father / mother/ same / neither

Father: extremely fast 1 2 3 4 5 can't drink

Mother: extremely fast 1 2 3 4 5 can't drink

Ep 25 Pressure of parental jaws while chewing.

Instruction:

Now see your parents chewing something. - Describe how they chew. - Do they chew with pressure? - Who chews with more pressure?

More pressure: Father / mother / same / neither

Father: violently 1 2 3 4 5 can't chew

Mother: violently 1 2 3 4 5 can't chew

Ep 26 Temperature and appearance of parental brains.

Instruction:

Now look at me. Imagine that my upper skull has been surgically removed and that you can see my brain. You can touch my visible brain with your finger and feel the temperature there. - Now picture your parents in a similar way. - Touch their brains alternately with your finger. You will similarly get a feeling od temperature there. - Describe the temperature of each parent's brain. Is it cold, warm or hot?

Hotter: Father / mother / same / neither

Father: extremely hot 1 2 3 4 5 extremely cold

Mother: extremely hot 1 2 3 4 5 extremely cold

Ep 27 Efficiency or inefficiency of parental brains.

Instruction:

Look at your parents' exposed brains again. - Imagine them as thinking machines, and describe how they look. - How do you feel about their efficiency as thinking machines? - Whose brain looks more efficient?

More efficient: Father / mother / same / neither

Father: very efficient / inefficient

healthy / unhealthy

Mother: very efficient / inefficient

healthy / unhealthy

Ep 28 Beating of parental hearts.

Instruction:

Now see your parents' complete images standing in front of you again. - Imagine that a window has been carved in each chest and that you can see their hearts beating there. - See the hearts beating, and describe how each parent's heart beats. - Is there any sign of anxiety in the heartbeats?

Stronger ' Father / mother / same / neither

Father: very anxious 1 2 3 4 5 not beating

Mother: very anxious 1 2 3 4 5 not beating

Ep 29 Appearance of parental intestines.

Instruction:

Now look at your parents' intestines. - Do they appear healthy or unhealthy? - Whose intestines appear healthier?

Healthier: Father / mother / same / neither

Father: very healthy 1 2 / 3 4 very unhealthy

Mother: very healthy 1 2 / 3 4 very unhealthy

Ep 30 Temperature and appearance of parental genitals.

Instruction:

Now see your parents' genitals. - Touch the genitals of each parent and describe the feelings of temperature there. - Describe how each parent reacts to the touch and any feelings you have while seeing this image. - Are there any memories associated with this image?

Healther: Father / mother/ same / neither

Father: very healthy 1 2 / 3 4 very unhealthy

Mother: very healthy 1 2 / 3 4 very unhealthy

SELF-IMAGE TEST

1. Child

I want you to imagine seeing yourself as in a movie. You are a child. What is the child doing? How is the child feeling? Have you anything to say to the child?

Child doing: postive / neutral / negative

Child feeling: +ve / neutral / -ve

Comment: +ve / neutral / -ve / nothing

2. Slim Adult Self

Now I want to imagine seeing yourself as a very slim adult. Notice what the woman in the image is doing, how she is dressed, and how she is feeling. Have you anything you want to say to her?

Confidence: +ve 1 2 3 4 5 -ve

Comment: +ve / neutral / -ve / nothing

3. Slim / Food

Now she is in the situation where there is a lot of food. Watch how she reacts to the food. Notice how she swallows and how she chews. How does she feel? Now she has a drink. How does she drink?

Reaction: +ve / neutral / -ve

Confidence:	+ve	1	2	3	4	5	-ve
Swallowing:	extremely fast	1	2	3	4	5	can't swallow
Chewing:	violently	1	2	3	4	5	can't chew
Drinking:	extremely fast	1	2	3	4	5	can't drink

4. Big self

Now imagine you are seeing yourself in the image again. You are very large. Notice what the woman in the image is doing, how she is dressed, and how she is feeling. Have you anything you want to say to her?

Confidence: +ve 1 2 3 4 5 -ve

Comment: +ve / neutral / -ve / nothing

5. Big / Food

Now she is in the situation where there is a lot of food. Watch how she reacts to the food. Notice how she swallows, and how she chews. How does she feel? Now she has a drink. How does she drink?

Reaction: +ve / neutral / -ve

Confidence: +ve 1 2 3 4 5 -ve

Swallowing:	extremely fast	1	2	3	4	5	can't swallow
Chewing:	violently	1	2	3	4	5	can't chew
Drinking:	extremely fast	1	2	3	4	5	can't drink

6. Side-by-side

Now I want you to imagine this thin-self and this big-self, side by side.

- what are they doing?

- how are they interacting?

= Do they want to talk to the other?

- How do they feel?

Communicating:

slim only / big only / both / neither

Slim: communication - friendly/neutral/hostile/none

Big: communication - friendly/neutral/hostile/none

Confidence: Slim,	very confident	1	2	3	4	5	no confidence
Big,	very confident	1	2	3	4	5	no confidence

Most confident: slim / big / same

D.13 Self-image Test

Summary of Self-Images (a) Self as a child

(b) Self as thin adult

(c) Self as thin adult in situation involving food

(d) Self as big adult

(e) Self as big adult in situation involving food

(f) Thin and large selves side by side in interaction

Appendix E

Corresponence

E.1 Newspaper Advertisement

"Are you Bulimic or a compulsive eater? If so, I need your help. I am a postgraduate psychology student researching eating disorders. Please phone ..... Warning: participation may be therapeutic."

E.2 Letters to participants

3 May 1989

Dear

Thank you for agreeing yet again to complete a battery of questionnaires for my research. As this is the final battery, I will be sending you some results of the study presently. I am very grateful for your participation, especially over such a long time.

I am looking forward to seeing you briefly (about 30 minutes) on _____

at _____

at Mellor House, 95 Union Street. Please bring your completed questionnaires with you.

Yours sincerely,

Dale Mercier

Dale Mercier,
c/o Psychology Department,
Otago University

11 June 1986

Dear

Thank you for replying to my advertisement in the "Otago Daily Times" re Bulimia/Compulsive eating. I would like the opportunity of explaining my research to you. To this end, could you telephone me urgently on 778-710 (home number), or leave a telephone number with the Psychology Department, phone 771-640, Extension 8815, so I can contact you. I would appreciate hearing from you as soon as possible as our programme begins soon.

Thank you once again,

Yours sincerely,

D. Mercier

Dale Mercier,
c/o Psychology Department,
Otago University,
Phone: 771-640, Ex. 8815

Dear

Thank you for replying to my advertisement in the "Otago Daily Times" re Bulimia/Compuslive eating.

My apologies for my delay in responding. The situation is that the present research is restricted to females because of the relatively larger number of females suffering from eating disorders.

However I realise that for some males it is every bit as traumatic as for females, and hope to do further research with males, in the near future.

To this end, I will contact you within the next month to tell you if this is possible.

Once again, thank you for replying,

Yours sincerely,

Dale Mercier

Dale Mercier,
c/o Psychology Department,
Otago University.

Dear

Thank you for replying to my advertisement in the "Otago Daily Times" re Bulimia/Compulsive Eating.

Unfortunately, participation in the present research would necessitate living in Dunedin as it involves weekly meetings. However, a large number of persons from outside the area responded and perhaps some sort of correspondence course could be arranged if enough people are interested. I will contact you as soon as possible if this can be arranged. Meanwhile, I would appreciate it, if you could contact me if you intend coming to Dunedin even for a short visit.

Thank you once again,

Yours sincerely,

Dale Mercier

Dale Mercier
c/o Department of Psychology,
University of Otago

12 June 1986

Dear

Thank you once again for taking part in my research. I would like to confirm your appointment times as being

_____ and _____ .

These meetings will take place in the building marked 'A' on the enclosed map. Go in the main door at the side of the building, and upstairs. There will be a room on your right marked 'Waiting Room". on the table will be a brief questionnaire. Please fill this in. There is also a toilet on this floor. I will be in the next room and will call you as soon as possible. Please help yourself to tea or coffee if you wish.

Enclosed are a number of questionnaires. It is not intended that you spend too much time on each one, although it is important to read the instructions carefully.

I would advise you to divide them up and do no more than two or three at any one time. Try to choose a time when you are alone and not likely to be disturbed. It is important to complete each whole questionnaire at one time. Please bring the completed questionnaires with you when you come for your appointment.

I would like you to be as honest as possible whilst answering the questions. You may notice that only your first name and initial appears on each questionnaire. The answers are coded and computerized to be used for statistcal purposes and are therefore strictly confidential.

As mentioned in our telephone conversation, there are a large number of people offering to take part. I really appreciate your help in this. Unfortunately, it may mean that some people will have to wait for their group sessions until September. These people will be chosen in a fair unbiased way (i.e. everyone has equal chance as in a lottery).

Once again, thank you for your participation,

Yours sincerely,

Dale Mercier

Appendix F

Case Studies—Two Failures and Two Successes

F.1 Case 1

Nancy presented as an attractive, intelligent, petite woman of 40 years. She was the mother of a child of eighteen months and lived with her partner. Her history of eating problems began with her father committed suicide. She was 15 years old at the time. She became 'anorectic' and remained so for some years without formal diagnosis. She was very shy socially and was unable to study or hold down a steady job because she didn't have the 'confidence'. She was about 21 years old when she met John and although she 'was not interested' he persevered and several years later they began living together. After they had tried unsuccessfully to have children she attended a fertility clinic, where she was offered fertility drugs. At no time was it suggested that anorexia was causing her infertility because it was 'easy to pull the wool over their eyes'. She finally became pregnant and was overjoyed as she believed that she would then be able to stop herself vomiting. However, this was not the case, and in spite of great guilt and despair Nancy continued her bulimic behaviour throughout pregnancy and after the birth. At the time of joining the study, she had been bulimic for some 25 years. A short attempt at working again after childbirth was difficult for her, and she and her partner both wanted another child. Consequently her days were involved with housework and childcare. She ate a 'normal' breakfast and lunch. Her bingeing and vomiting began at 6.00pm and continued until 10.00pm six nights per week, although they had not always followed that pattern. She was socially withdrawn and visited few persons during the day. In the evenings (6 days per week) her partner visited his favourite hotel,

where, according to Nancy, he was the centre of attention. She didn't 'enjoy that sort of thing'. Nancy claimed she took part in the programme because she wanted to help with the research and she was 'curious'. She was also desperately concerned because her 4-hour nightly binges were putting a huge strain on the family budget and she was having difficulty explaining their cost (her partner had always 'known of her problem')

She was surprised that she was able to take part in the group sessions and was popular with other members. After the first three weeks she began to report a growing dissatisfaction with her lifestyle. She was no longer content staying at home all day and every evening whilst John went to work, and later to the hotel. She was also unhappy with her living accommodation. By the end of the sessions she recognised that her bingeing and purging behaviours helped her cope with her situation. She made the decision to stay with her partner of 20 years, even if it meant continuing to behave in ways she did not like. She 'knew' now that she was able to stop if she was prepared to take the consequences (i.e. separation). At this point, it would have been appropriate for her and her partner to take part in some sort of marital guidance, especially as he had been threatened by the changes she had been making throughout the course (her interpretation of his behaviour). Nancy felt the course had been worthwhile to her as she had more understanding and tolerance towards her behaviour. Furthermore, she now knew she could stop it if she so desired. She was not able to bring herself to attend the three month follow-up as she was 'ashamed' that she had not improved enough. This was in spite of the fact that there was no peer or leader pressure to change her behaviour in any way.

By three year follow-up Nancy's behaviour had changed sufficiently to allow her to become pregnant again and she had given birth to a second healthy child. Her bulit score had dropped from 116 to 90 (116, 104, 103, 90). She was not depressed at pre-treatment assessment (score = 1) but increased her score slightly as her bulit score decreased i.e., she became more depressed. However, her score of 3 at 3-year follow-up continous to be in the mildly depressed category. Her scores on measures of wellbeing, self-esteem, and anxiety remained relatively stable.

Although her lifestyle has changed little, Nancy claims to be 'much happier' and more accepting. She now no longer vomits several times each night but has reduced it to several times per week. However, the secondary gain of her behaviour, preserving her relationship with her partner, makes it likely that her bulimic behaviour will continue.

F.2 Case 2

Judy was a woman in her late twenty's who wanted to join the study because she was 'desperate'. She lived alone with her two children, but had been married. Her childhood had been incredibly unhappy. So unhappy, she claimed, that she can't remember very much about it. She had suffered physical abuse at the hands of her stepfather, and had left home at an early age and had become pregnant. She later married (not the father of her child) and was relatively happy for a short time. After having another child, she discovered that her husband had been having affairs outside the marriage. She was the last to know. Soon after this, when her oldest child was six, it was found that her husband had been sexually involved with the child. Her eating problems began at this time. She was devastated and at the time of the sessions (two and a half years later) 'hated all men!' Furthermore, she believed herself 'repulsive and fat, so it's a two-way thing'.

Along with many women in the group Judy was very non-assertive. She had a number of 'friends' who used her as a baby sitter. Even though she had children of her own, they would drop off their own children and pick them up hours later. At weekends, she would be caring for up to 8 children, and providing food for them. No reciprocal arrangements were made, and Judy was struggling to make ends meet on the welfare payments. She found role-playing saying 'no' difficult and after having moderate success, applied her new found skills to limit baby-sitting occasions. Some of her former 'friends' would no longer talk to her and she wondered 'what was the use?' Other members in her group persuaded her that those who merely used her for baby-sitting were not real friends. During the seven weeks Judy confronted a number of issues in her life. For example, she had been feeling very guilty because a jug of boiling water had nearly killed her youngest child, who was hospitalised for some time, and was badly scarred. Judy did not know whether the 'accident' happened on purpose or not. She suffered occasional attacks of amnesia. Some of these related to men. For example, on one night she remembers going to a hotel with acquaintances. She 'woke up' hours later to find herself in bed with a strange man. She remembered nothing of the encounter but presumed she had had intercourse with him. She dressed without waking him and returned home to 'eat everything in the house'. Judy scored 15 on the Beck Depression Inventory pre-treatment, which is approaching the 'severely depressed' category (16+). At post-treatment, Judy's score climbed to 21 and her bulimia deteriorated from a score of 110 to one of 120. She was contacted by the group leader who suggested she might see a psychologist for further help. She declined, and by 3-month follow-up, her level of depression dropped to 10 (moderately depressed), and her

bulimia returned to pre-treatment level (110). Trait anxiety also dropped from pre-treatment score of 51 to the follow-up score of 42. At the three month reunion of her group she said she had 'sorted a few things out' and was not just doing what people asked her to do. Two years after this Judy's mother became ill with cancer and Judy nursed her for some months with no help from other family members. Not long after her mother died she sought help from a psychologist for a number of problems but was told that there was nothing the psychologist could do to help her. Presumably her problems were seen in the light of her recent bereavement, and her need to have undergone several operations, and it was thought they would pass with time. However, at the time of the three year follow-up, Judy was still severely depressed (score = 21) and her self-esteem was very low (30). Her score of 60 on the STAI Trait Anxiety Scale was extremely high (norm about 36 for her age group). Ironically, her Bulit score decreased from a post-treatment score of 120 to a score of 104. Although others had higher scores on initial measures of depression and self-esteem at pre-intervention, Judy did not respond well to this brief group intervention. Perhaps her social isolation combined with an extraordinary number of negative life experiences preclude the possibility of a 'simple' solution to her problems.

F.3 Case 3

Jane was an attractive young woman of slight build. She was married with one child. She and her husband had been wanting another child but had not been successful. Jane thought that it might have been because she had been on a long 'crash' diet and was not menstruating. She was also doing a great deal of exercise. Although she felt fat, she suspected she was anorectic and that this was affecting her fertility. She broached this possibility with both her general practitioner and the specialist but neither thought it was causing the problem. Consequently, the specialist decided an exploratory operation was called for, and despite her suspicions and misgivings, Jane agreed to this. Unfortunately, there were a number of complications as a result of the operation and she was left with a very large scar. No cause for her infertility was found however.

After this time, Jane's eating problems increased in intensity. Not only did she believe she was fat, but she thought the scar very ugly. She increased her exercise programme again as soon as she had recovered sufficiently, and at the time of post-intervention saw herself as a 'compulsive' exerciser.

Realising she had severe problems, Jane was seen by a clinical psychologist for a total of nine months, without any progress from her point of view. Shortly

before, she had discovered a book called 'Fat is a Feminist Issue' (Orbach, 1978) and was excited by the ideas presented in it. Her psychologist was not sympathetic and she decided to look elsewhere for help.

Of all the subjects Jane appeared most 'ready' for the orientation of the sessions. She conscientiously carried out all suggestions and found that they 'really worked'. She was an excellent role model for other group members (Group One) and by post-intervention, her Bulit score had decreased from 122 to only 47, well below the norm (74.3). Her score for self-esteem, previously high at 26, dropped to 13 (low score indicates high esteem on a range of 10–40). Trait anxiety depression and wellbeing measures all showed similar remarkable changes (57 to 26, 6 to 2, and 0.65 to 3.00 respectively).

By the three-month follow-up Jane had recommenced menstruating and had conceived another child. Her exercise programme consisted only of activities she enjoyed about three times a week. Her Bulit score at this time dropped further to 38 (lowest score possible is 32), and all other measures were maintained at post-intervention levels.

At the three year follow-up Jane presented as a confident, enthusiastic woman, very happy with every aspect of her life.

F.4 Case 4

This case was chosen because it represents some sort of 'average' of those participating in the programme.

Mary was a very attractive but overweight person who suffered very low self-esteem (33), was anxious (Trait score = 63) and depressed (11). Although she felt she did well at her job as a nurse, in all other aspects of her life she was a 'failure'. Her problems with food began at a very young age. She was dissatisfied with her shape and weight from the age of seven years but did not resort to vomiting until the age of 24 years. She came from a family where mother, father, sister and brother all had eating disorders or dieted frequently.

She had tried a number of methods to lose weight as well as dieting, including Weightwatchers, counselling, and psychotherapy. Typically she would lose weight then panic and start bingeing again. In answer to the question 'why do you think the problem may have been started initially?' Mary wrote 'the need to make myself ugly. The need to use food for security and warmth and love.' At 28 years Mary wanted a relationship but felt very afraid of the possibility. During the course of the first weeks of intervention, she reached the conclusion that her need to be overweight began as a child when she was a victim of incest (her father) and she had

been told repeatedly what a lovely little body she had. By the completion of the course she had come to see her weight in a positive rather than a negative light, as a protection from men's sexual advances. At the same time she was attempting to learn new skills to accomplish what her 'fat' had achieved before she learned to say 'no' to advances rather than rely on looking 'repulsive'.

After intervention, Mary was still in the process of making many discoveries about herself and changing her lifestyle. She continued to overeat but did not have the same degree of guilt. She no longer vomited however. She made a rational decision to remain 'safely' overweight until she was ready, and also to put off the idea of having a relationship until she 'sorted herself out'.

At the three year follow-up Mary felt happy with her progress. She had decided that about 6 kg per year would be a 'safe' amount to lose and had lost this amount each year (i.e., 18 kg). Her living arrangements had become more stable and although she had not yet entered into a relationship, she felt more comfortable in many situations.

Her level of bulimia had decreased from 129 at pre-intervention to 74 at post-intervention and improvements were maintained over three years. A depression score of 11 dropped to 3 at post-intervention and to 0 at long-term follow-up. Her self-esteem rose during this time (a score of 33 to 20 over the three years), and anxiety levels dropped (63 to 35). Her overall wellbeing showed a positive increase (−0.25 to 1.8). Mary is typical of many women for whom binge-eating and/or being 'overweight' has an obvious function.

Appendix G

Statistics and data

TABLE G.1: Pearson Correlation Coefficients for test results post-intervention. (n=24)

	Bulimia	State Anxiety	Trait Anxiety	Wellbeing	Depression	Esteem
Bulimia		.454*	.508**	-.624****	.436*	.496**
State Anxiety			.905****	-.678****	.617****	.400*
Trait Anxiety				-.784****	.648****	.560***
Wellbeing					-.730****	-.623****
Depression						.546*

* $p \leq .05$
** $p \leq .01$
*** $p \leq .005$
**** $p \leq .001$

TABLE G.2: Pearson Correlation Coefficients for test results at 3-month follow-up (n=16)

	Bulimia	State Anxiety	Trait Anxiety	Wellbeing	Depression	Esteem
Bulimia		.682***	.735****	-.752****	.701****	.707****
State Anxiety			.833****	-.823****	.768****	.511*
Trait Anxiety				-.938****	.716****	.804****
Wellbeing					-.809****	-.809****
Depression						.574**

* $p \leq .05$
** $p \leq .01$
*** $p \leq .005$
**** $p \leq .001$

TABLE G.3: Raw data for Bulit Questionnaire

	SS	Pre-	Post-	3-mth	3-year
Group 1	1	122	47	38	43
	2	127	108	116	101
	3	129	74	82	77
	4	121	95	69	88
	5	105	44	44	40
	6	95	53	49	(66)
	7	111	103	63	62
	8	114	66	44	50
Group 2	1	94	110	89	85
	2	125	78	70	47
	3	111	120	110	104
	4	131	130	(99)	73
	5	106	77	73	84
	6	116	104	103	90
	7	105	111	110	103
	8	126	113	134	67
Group 3 (waiting-list control)	1	124	132		
	2	120	111		
	3	108	110		
	4	96	117		
	5	119	109		
	6	110	101		
	7	122	111		
	8	132	119		

Note: Missing Data. One subject did not complete the 3-month assessment battery of questionnaire, and another did not complete the 3-year battery (see brackets above). These missing data were replaced by group means for all variables, giving a conservative (i.e., unfavourable) estimate of the missing data.

TABLE G.4: 2-way ANOVAs of Groups 1 and 2 from pre-intervention to 3-month follow-up, and from post-intervention to 3-month follow-up

Source	df	SS	MS	F	
Group(G)	1	5742.19	5742.19	7.15	*
Error between	14	11245.29	803.24		
Bulimia(B)	2	10042.13	5021.06	24.61	
B x G	2	3234.88	1617.44	7.93	
Error within	28	5712.33	204.01		
Group(G)	1	8944.53	8944.53	9.62	**
Error within	14	13017.19	929.80		
Bulimia(B)	1	621.28	621.28	4.6	*
B x G	1	26.28	26.28	.19	
Error within	14	1888.93	134.92		

* $p < .05$
** $p < .01$

TABLE G.5: Summary of test results across all measures at 3-year follow-up

Dependant Measure	Mean	SD
Bulimia	73.75	21.34
Wellbeing		
Negative	- 0.84	0.69
Positive	2.55	0.66
Esteem	16.38	6.91
Anxiety		
State	31.25	8.50
Trait	37.56	9.55
Depression	3.63	5.18

TABLE G.6: Raw data for expectations

Group 1 (n = 8)

Score	0	1	2	3	4	5	6	7	8	9	10	mean
Question 1				1	1	1	11	1	1		1	6.13
2					1	11	1	1	1	11		6.53
3									11	1	1111	9.38

Group 2 (n = 8)

Score	0	1	2	3	4	5	6	7	8	9	10	mean
Question 1	1			1	1	1	1	1	11			5.13
2	1			11	1	1	1	1	1			4.5
3			1			11		1			1111	7.44